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The Texas Plan to Combat Mental Retardation.

Governor's Advisory Committee on Mental Retardation Planning, Austin, Tex.; Governor's Interagency Committee on Mental Retardation Planning, Austin, Tex.

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The Texas state plan of action against mental retardation is presented. Aspects considered include the evolution of the plan, the role of the health services, medical aspects of retardation, education and training, vocational rehabilitation and employment, and social welfare. Also surveyed are the following: residential and day care, manpower, research for prevention and cure, Texas law concerning the retarded, local action and public awareness, organization and coordination of statewide and community efforts, and legislation and finance. (LE)

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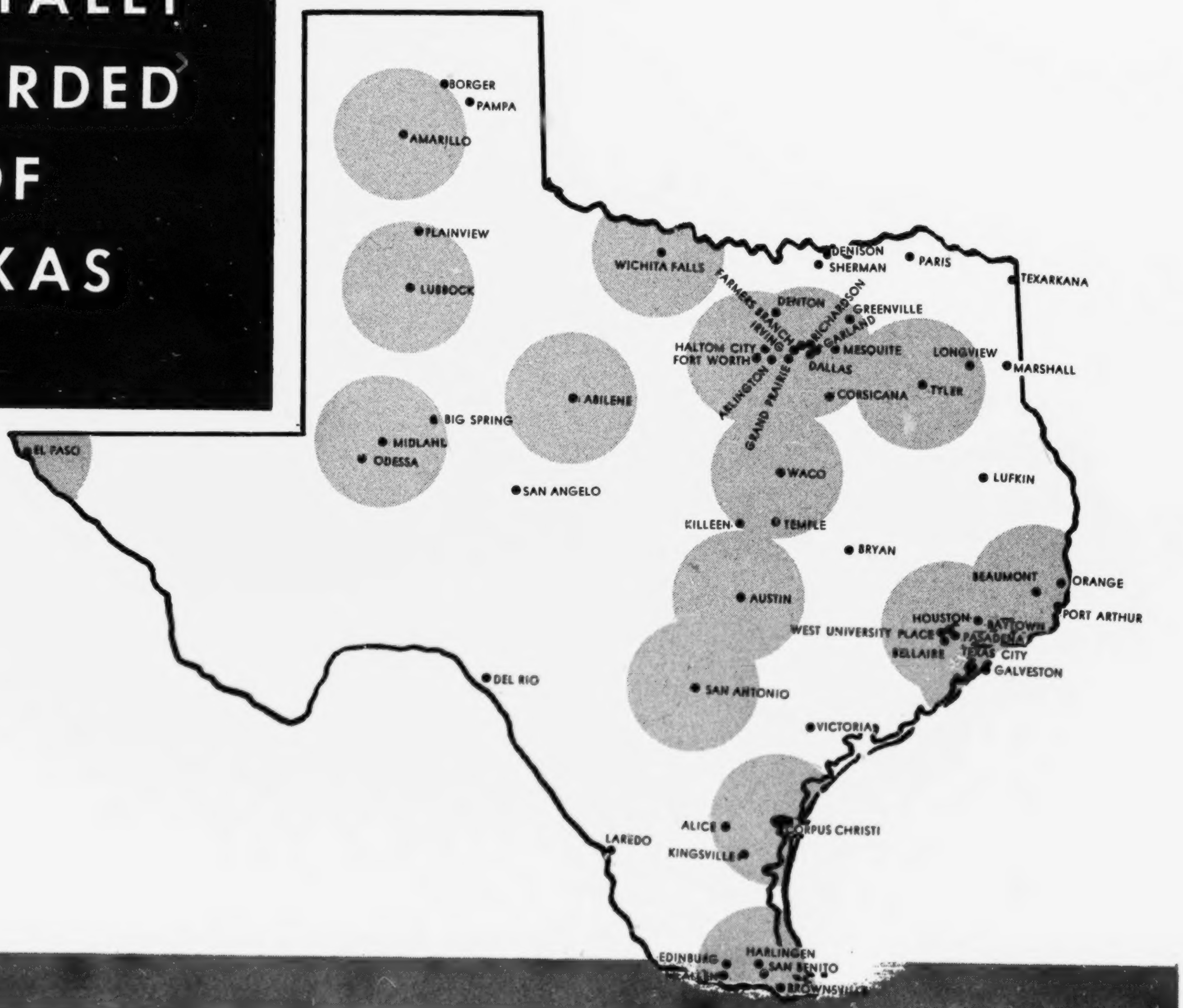
HELPING THE MENTALLY RETARDED OF TEXAS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The Texas Plan to Combat Mental Retardation

EC 003 519E

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THE TEXAS PLAN TO COMBAT MENTAL RETARDATION

Prepared By The

GOVERNOR'S ADVISORY COMMITTEE ON MENTAL RETARDATION PLANNING

And The

GOVERNOR'S INTERAGENCY COMMITTEE ON MENTAL RETARDATION PLANNING

Austin, Texas

June, 1966

JOHN CONNALLY
Governor

INTERAGENCY COMMITTEE ON MENTAL RETARDATION PLANNING

TEXAS MENTAL RETARDATION PLANNING STUDY

Office Location:
4405 N. Lamar Blvd.
Ph. GL 3-7231

STUART C. FISHER, M.P.H.
Planning Director

Mailing Address:
Box S, Capitol Station
Austin 78711

INTERAGENCY COMMITTEE

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SPECIAL CONSULTANT
Charles Meisgeier, D.Ed.

TO THE GOVERNOR, THE INTERAGENCY COMMITTEE, AND THE PEOPLE OF TEXAS:

Completion of the Recommendations for the Development of the Texas Plan to Combat Mental Retardation was another important step in our continuing statewide and community efforts to provide better care and more comprehensive services for the mentally retarded.

Thousands of Texas citizens, and public officials at every level of State and local government, have contributed time, talent, and energy to this project. They have worked together in:

* Public briefings in 17 major cities.

* Mayors' Commission studies in 58 Texas cities.

* State Task Force writing sessions which brought the findings and recommendations together.

* Periodic sessions of the Governor's Advisory Committee.

* Day-by-day work of the State agencies serving the retarded and the State Planning Office.

All of the efforts which went into the preparation of the recommendations are greatly appreciated. After approval by your statewide Governor's Advisory Committee, on behalf of the many people who assisted in their preparation, the recommendations were printed in final form and presented to the Honorable John Connally, Governor of Texas, at the Governor's Conference on Mental Retardation in Austin, Texas, on March 17, 1966.

Your Advisory Committee is indebted to you for your leadership and participation in this planning effort and earnestly solicits your continuing support in carrying into action the recommendations embodied in the Texas Plan to Combat Mental Retardation.

THE GOVERNOR'S ADVISORY COMMITTEE

Herman Jones

Herman Jones, Chairman

This study was supported in part
by a Mental Retardation Planning Grant
awarded by
The Public Health Service,
Department of Health, Education, and Welfare

FOREWORD

Texas is taking an active part in the nationwide offensive against mental retardation. *The Texas Plan to Combat Mental Retardation* is the State's blueprint for action.

The Governor's Interagency Committee, composed of chief State officers whose agencies have direct or indirect responsibilities for providing services to the mentally retarded citizens of Texas, accepted the *Recommendations for the Development of the Texas Plan to Combat Mental Retardation* from the Governor's Advisory Committee.

These recommendations, with certain revisions deemed necessary by the Interagency Committee, are presented in this book as the official *Texas Plan to Combat Mental Retardation.*

Some of the recommendations are directed at the people of Texas in their local communities. Grass roots support will be required for their successful implementation. Other recommendations will require the acceptance of the Texas Legislature if they are to be translated into State law.

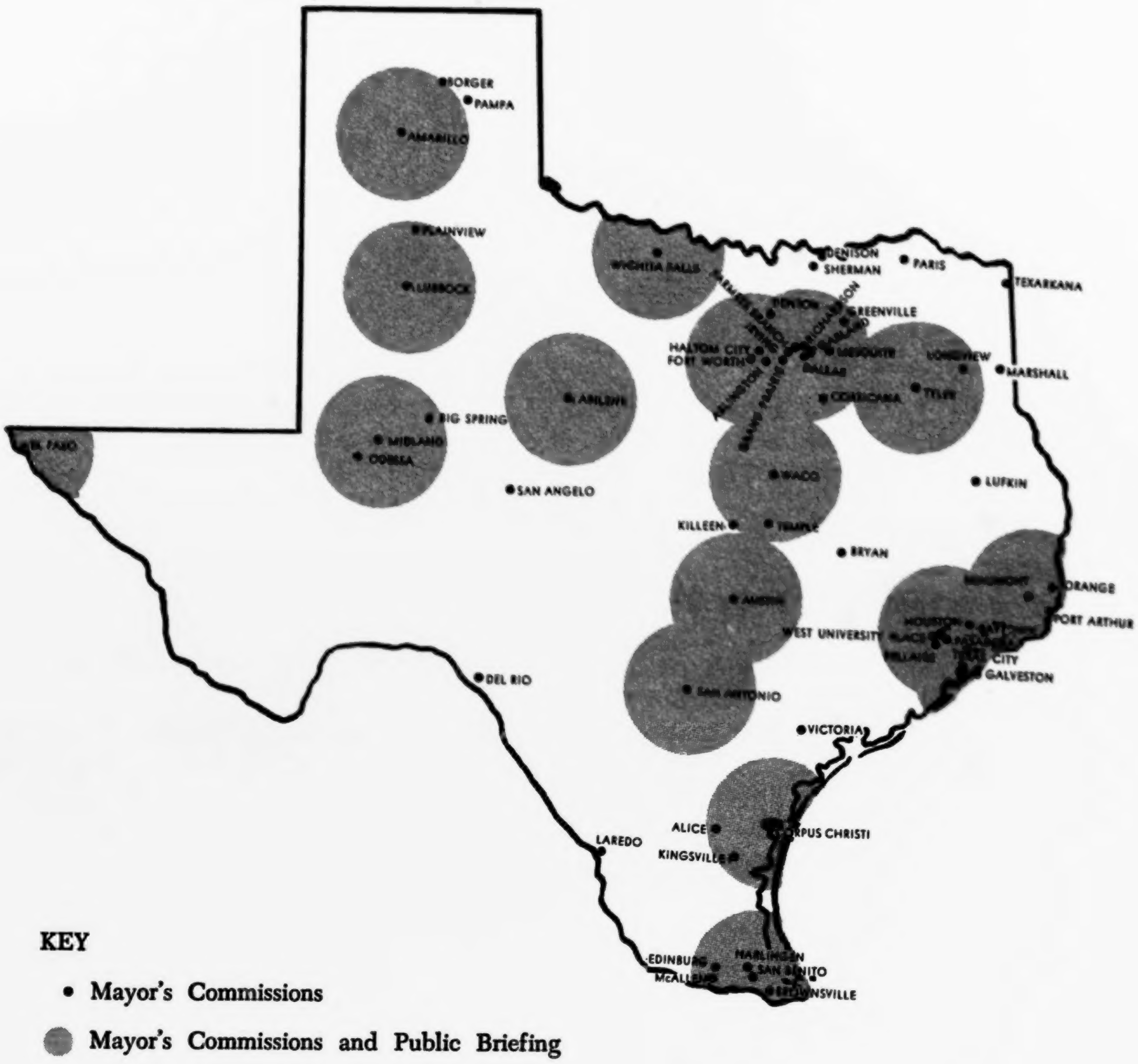
Still other recommendations are directed at certain State agencies, as represented by the members of the Governor's Interagency Committee. These agencies will do what they can—within the limits of staff, finances, time and legal authorization—to help implement the Texas Plan recommendations.

THE GOVERNOR'S INTERAGENCY COMMITTEE

Bill B. Cobb

Bill B. Cobb, Chairman

June, 1966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KEY
• Mayor's Commissions
● Mayor's Commissions and Public Briefing

Map showing areas covered by Public Briefings and cities with active Mayor's Commissions

The 17 Texas cities represented by Public Briefings on Mental Retardation Planning are indicated by the large circles on the above map. Cities represented by the Mayors' Commissions are named and indicated by the small dots covering all major population centers in Texas. (Map drawing courtesy of *Texas Talk*, official publication of the Texas Association for Retarded Children.)

CONTENTS

Page

Letter of Transmittal from the Governor's Advisory Committee iii

Foreword v

Contents vii

1. Evolution of the Texas Plan 1
2. The Role of Health Services 7
3. Medical Aspects of Mental Retardation 21
4. Education and Training 37
5. Vocational Rehabilitation and Employment 41
6. Social Welfare 45
7. Residential and Day Care for the Retarded 51
8. Manpower—The Key to Providing Needed Services 59
9. Research for Better Methods of Prevention and Care 63
10. Texas Law and the Mentally Retarded 67
11. Local Action and Public Awareness 73
12. Organization and Coordination of Statewide and Community Efforts 79
13. Legislation and Finance 83

Appendix 85

- Interagency Committee on Mental Retardation Planning 85
- Governor's Advisory Committee on Mental Retardation Planning 85
- The 12 State Task Forces 86
- The 58 Mayors' Commissions on Mental Retardation Planning: Mayors, Commission Chairmen, Members 87
- Chairmen, State Agency Planning Committees 98
- State Planning Office Staff 98

1. EVOLUTION OF THE TEXAS PLAN

MENTAL RETARDATION DEFINED

The mentally retarded are identified as children and adults who, as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the society in which they live. Two general types of mental retardation exist: (1) Those conditions which are the direct result of organic pathological processes, either anatomical or bio-chemical, which damage the brain, and (2) those conditions which result from environmental circumstances and have no known physiologic or anatomic basis but are either psychogenic or socio-cultural in origin.

Fifteen to twenty per cent of the mentally retarded suffer from the first, or pathological type. It has been estimated that there are two or three hundred diseases resulting in pathological damage to the brain, many new diseases being discovered monthly. Among these diseases or conditions is Down's Syndrome, better known as Mongolism, a disease associated with abnormality of the chromosomes of the body cells.

Prematurity results in subnormal intelligence in many cases, also abnormal development of the brain of the infant during pregnancy. This may occur when the mother contracts German measles or suffers from some other disease during the early weeks of pregnancy. Children who survive brain damage due to meningitis, encephalitis, accidents, and poisoning are common in the mental deficiency category. Also among the etiological factors are hereditary diseases such as phenylketonuria and galactosemia and many other similar types of disease.

The second type of mental retardation is the more common. It is socio-cultural in nature. It occurs in children of the more disadvantaged classes of society characterized by low income, limited educational opportunity, unskilled occupation, and generally impoverished environment. These families concentrate their limited energy on making ends meet; they have neither the means nor the skill to provide their children with stimulating environmental surroundings such as good conversation, books, and other intellectual and cultural advantages which are almost automatically bestowed upon children of the middle and upper income groups.

Children in these less fortunate families arrive at school age equipped with neither the experience nor the skills necessary for formal education. They are backward in language and in the ability for abstract thinking which is necessary for reading and writing and numerical activities.

From these families come many of the dull, borderline individuals who fill the special classes. Their failure to learn becomes complicated by frustration and anxiety, and some may graduate into patterns of delinquency or ultimately to an institution.

SIZE AND SCOPE OF THE PROBLEM OF MENTAL RETARDATION

In the United States: It is estimated that there are more than 5½ million people in the United States (3 per cent of the population) who should be identified as mentally retarded before they are 15 years of age. By 1970, natural population growth can be expected to increase the total to 6½ million unless very stringent preventive measures can be introduced. Estimates made in 1963 and reported by the National Association for Retarded Children indicate that there are about 5 million mildly retarded individuals, 350,000 moderately retarded, 200,000 with severe retardation, and a much smaller group of about 85,000 who are profoundly handicapped by mental retardation.

In Texas: No state, including Texas, can provide an accurate count of the number of mentally retarded persons in its population because of the difficulties of making a "head count," inconclusive diagnoses, families on the move, and other factors. However, certain counts of limited populations of mentally retarded persons in Texas are a matter of record.

In 1965-66 the Texas public schools were providing special classes for 24,602 educable retarded children and 2,634 trainable retarded children, for a total of 27,236. The six State Schools for the Mentally Retarded recently reported populations totaling about 11,500.

Several hundred more retarded persons are enrolled in private schools and care facilities across the State. Thus, while a generous estimate would identify some 41,000 retarded persons receiving services in Texas, 3 per cent of the State's current population (.03 x 10,230,209) would indicate a presumed population of nearly 307,000 retarded persons. This leaves a balance of about 266,000 Texas citizens who are presumed to be retarded to some degree, but who are probably undiagnosed and certainly untouched by organized services, either local or State.

The number of births in the State is about 240,000 live births per year. The use of an incidence factor of 3 per cent of the total population indicates that 7,200 of these live births each year (1 in every 33) will be mentally retarded.

Only four significant disabling conditions—mental illness, cardiac disease, arthritis, and cancer—have a higher prevalence; but they tend to come late in life, while mental retardation comes early. Mental retardation afflicts twice as many individuals as blindness, polio, cerebral palsy, and rheumatic heart disease combined.

The State of Texas is denied many millions of dollars of economic output because of the underachievement, underproduction, and in some cases complete incapability of the mentally retarded. Much human anguish and loss of happiness and feeling of well-being results from the presence of mental retardation in thousands of families in Texas. The cost of caring for a mentally retarded person is staggering; estimated cost of lifetime care for the retarded in state institutions approaches $100,000 per person. However, economic costs cannot compare with the misery and frustration that parents realize in attempting to get their child prepared for something close to a happy, productive adulthood.

As the President's Panel on Mental Retardation so dramatically pointed out, there is need for activity in many areas to combat this problem. Much needs to be done in preventive research, in the extension of public health services, and in welfare services. The public school programs are reaching only a few of the many children who need this service. Recruitment of teachers for the educational programs must be stepped up drastically. Techniques for identifying, diagnosing, and referring young retarded children to the proper programs is dependent upon the development of more adequate centers and better diagnostic procedures.

New approaches must be developed legally to provide for protective services, guardianship, and economic security for the retarded adult. A constant improvement and expansion of state-supported institutions and facilities is part of the total picture, even though relatively few of the retarded will be using large centralized facilities. The most extensive plans today are for the rapid improvement of *services at the community level*, and much of the following report is designed to assure more grass roots interest and more community support for these many services needed at home for all ages and all levels of the retarded population.

THE TEXAS PLAN TO COMBAT MENTAL RETARDATION

After many years of planning and working, Texas is ready to wage all-out war against retardation, which now blights the lives of more than 300,000 Texans. *The Texas Plan to Combat Mental Retardation* is ready. It will become the battle plan for a massive assault against retardation in all its forms. Governor Connally took the first steps in preparation for such a giant effort in February, 1964 when he appointed the Interagency Committee on Mental Retardation comprised of the chief executives of seven Texas state agencies whose programs represented the nucleus of services for the retarded. To chair this important group Governor Connally appointed his Executive Budget Director, Bill B. Cobb.

Shortly thereafter, the Governor appointed an Advisory Committee on Mental Retardation made up of leading citizens of Texas from business, the professions, and organizations such as the Texas Association for Retarded Children. An able civic leader, the Honorable Herman Jones, Judge of the 53rd District Court, was appointed by the Governor to serve as chairman. The original 20-member committee was expanded to 53 members in October, 1964.

While the Connally administration in Texas was mobilizing for strong action on behalf of the retarded, the Kennedy administration was moving with great force on the national scene. In fact, the last piece of legislation signed by President Kennedy before his death was the one which provided the foundation for all state planning. It provided $2.2 million "to assist the states in planning comprehensive action to combat mental retardation."

THE NATIONAL PLAN TO COMBAT MENTAL RETARDATION

In October, 1961 President Kennedy appointed a panel of 27 scientists and specialists in mental retardation and presented them with a mandate to prepare a *National Plan to Combat Mental Retardation.*

One year later, in October, 1962 *A Proposed Program for National Action to Combat Mental Retardation* was presented to the President. It outlined the size and scope of the problem in the United States and provided a blueprint for a comprehensive program of action to prevent mental retardation and to minimize its effects on human development.

The President's Panel report formed the basis for two extremely important pieces of legislation passed by the 88th Congress. They ushered in a new era in the care of the mentally retarded—a shift from custodial care in institutions set apart from communities to a new emphasis on prevention and community-centered treatment and rehabilitation. The first, P.L. 88-164, provided the funds to plan for the construction of mental retardation facilities; the second, P.L. 88-156, provided funds to each state to set up Mental Retardation Planning Projects.

TEXAS MENTAL RETARDATION PLANNING STUDY

The Texas Mental Retardation Planning Study came into being in July, 1964. Its director was Stuart C. Fisher, M.P.H., a man with broad knowledge of Texas state government and public administration and a wide interest and background in the health field. At the time of his appointment, Mr. Fisher was Director of Administration for the New Mexico State Department of Health.

Charles Meisgeier, Ed.D., special consultant, brought to the project a wide-ranging, fiirsthand knowledge of mental retardation in Texas along with national professional recognition in the field. Together they produced a "Plan for Planning" that probed into local communities, into the homes, schools, and job situations of the retarded, obtaining firsthand knowledge of their problems and needs. Where else could the real answers be found?

Specifically, the goal of the planning study was the development of a blueprint for a massive assault against mental retardation in all the areas of Texas life where its blight is found. A bold plan was needed that would bring together the now-splintered efforts of thousands of Texans laboring in unrelated programs for the retarded and to add to them thousands more in urgently needed new programs.

PHASE 1—DEVELOPING THE TEXAS BATTLE PLAN

How to combat mental retardation? Texas needed a plan. How to develop a plan? Texas needed a Plan for Planning. Mr. Fisher and Dr. Meisgeier, architects of the Plan for Planning, developed a structure to guide Texans in the study of their own needs. It provided the opportunity for parent groups, state agencies, and any interested citizens to participate in the development of the *Texas Plan to Combat Mental Retardation.*

The Planning Plan was completed in September, 1964 and approved at the first meeting of the Governor's Advisory Committee on Mental Retardation and by the Governor's Interagency Committee.

PHASE 2—PUBLIC BRIEFINGS AND STATE AGENCY PLANNING

Thousands of Texans from all fields and professions, from State and private agencies and from all walks of life participated in the second phase of the planning. Seventeen highly successful Public Briefings were held in key population centers throughout the State.

Prior to the briefings, each of the 17 chairmen attended a special workshop in San Antonio conducted by Mrs. Dora Huston, chairman of the Public Briefings Committee and one of the most capable and active women on the Texas scene today. Special materials—film clips, speeches, press releases, radio and TV spots, and resource materials—were distributed to each chairman, thus assuring uniformity of presentation at each of the 17 meetings.

Each Public Briefing presented a detailed overview of the problems involved in mental retardation and of its scope. The purpose and methodology of the Texan Plan was thoroughly presented and discussed. Attendees were urged to participate in the planning activities in their local communities.

The State agencies represented on the Interagency Committee were also deeply involved in planning. Each one appointed its own agency planning committee to do a thorough study of its program and to develop its recommendation for the comprehensive plan to combat mental retardation.

PHASE 3—MAYORS' COMMISSIONS: HEART OF THE PLANNING

Every Texas community of any size was active in the third and largest phase of the planning. Community leaders, parents, concerned citizens, public officials at every level of governmental and civic life expressed the needs of the retarded as they saw them. How?

The mayors of 58 Texas cities with populations of 19,000 or more responded to Governor Connally's request to establish Mayor's Commissions on Mental Retardation Planning. To prepare for the work confronting them, the Commission chairmen attended a two-day workshop in Austin to study their manual, *Guidelines for Community Planning in Mental Retardation,* prepared and developed for use by the Commissions.

Each Commission was organized into seven task force study areas: Health, Education, Welfare, Rehabilitation and Employment, Residential and Day Care, Law and the Mentally Retarded, and Public Awareness and Local Action.

Specific data were collected by each task force, facilities and programs were studied in detail, legislation was recommended, gaps and overlaps in services were described. Each task force report then was reviewed by the whole commission, compiled and finally approved in open meeting. The final report of each Mayor's Commission was presented formally to the Mayor and the City Council of each of the 58 cities.

In nearly every case the city fathers were taken aback by the scope of the problem. Wholehearted support was given to the work of the commissions. The Commission reports—springing from local communities and prepared by parents, teachers and those working directly with the retarded—make up the bedrock foundation of the Texas Plan as it finally evolved. Thus the Plan reflects practical needs as expressed on the homeground of the retarded rather than wholly from academic thought or "expert" opinion.

With the receipt at the planning study headquarters in Austin of the complete Mayors' Commission reports, the third phase of the Planning Project was completed.

PHASE 4—SECOND SERIES OF PUBLIC BRIEFINGS

A second series of Public Briefings was held in May, 1965—again under the capable leadership of Mrs. Huston. The purpose of these meetings was to hear the reports of the Mayors' Commissions, to bring regional needs into focus, and to present them to the public.

Again a preparatory meeting was held for briefings chairmen, and special materials were prepared to publicize the work of the local commissions and to announce the Public Briefings. Governor Connally made a video tape. Dan Blocker of "Bonanza" television fame and Judge Jones narrated additional video and radio tapes for statewide use.

PHASE 5—STUDY OF MAYORS' COMMISSION REPORTS

Great stacks of material were received and processed in the Planning Office. Special State Reports, Mayors' Commission Reports, Agency Reports, and other materials had to be studied and separated into areas of specialty. Mr. John Jackson and Mr. Preston Clark had joined the TMRPS staff to help Mr. Fisher and Dr. Meisgeier with the work. This phase of the planning was completed in September, 1965 when the data were compiled into a publication titled *Guidelines for State Task Forces on Mental Retardation Planning.*

Information in "Guidelines" included a composite of the recommendations compiled by the seven task force areas in the 58 communities. Also included was information prepared for task force action in five other major areas: Medical Aspects of Mental Retardation, Research and Training, Manpower, Organization-Coordination, and Legislation and Finance.

PHASE 6—STATE TASK FORCES

These recommendations for the development of the *Texas Plan to Combat Mental Retardation* began to take final shape under the 12 State Task Forces appointed by Advisory Committee Chairman, Judge Jones.

Dr. Sam Nixon of Floresville put all the data of health services, the report of the Department of Health, the recommendations from the Mayors' Commissions, and other materials before the members of his Task Force on Health Services for the Mentally Retarded. Together they formulated a single plan for coordinated State and local action to meet the needs of the retarded for health services. Each Task Force worked the same way.

Dr. Richard H. Hungerford of Victoria chaired the Task Force on Education. Mr. Wilfrid Calnan of Corpus Christi headed the group that worked on Welfare Services. Mr. George Parker, a Fort Worth attorney, chaired the Task Force on Law; Mr. Frank Borreca of Houston, the one on Vocational Rehabilitation and Employment. From Fort Worth, Mrs. E. E. Searcy took charge of the Task Force on Residential and Day Care.

Mrs. Marilyn Schwartz, wife of the State Senator from Galveston, served as chairman of the Task Force on Local Action and Public Awareness. Dr. John R. Peck of the University of Texas in Austin headed the Research Task Force; and Dr. George A. Constant, Victoria, was in charge of the Manpower Development Task Force. Dr. Philip Roos, Austin, was chairman of the Organization and Coordination Task Force; and Dr. Doman K. Keele of Denton headed up the group working on the Medical Aspects of Mental Retardation. The Task Force on Finance and Legislation was directed by State Representative G. F. (Gus) Mutscher of Brenham, Chairman; and Dr. Meisgeier, Co-Chairman. This phase of the work was completed in December, 1965.

PHASE 7—THE FINAL PLAN

The work of the State Task Forces was blended into a single workable plan. Called the *Preliminary Draft of the Texas Plan to Combat Mental Retardation,* this document was reviewed by the Interagency Committee and various reviewing and writing committees. Each Agency Planning Committee edited and revised the Task Force reports pertinent to its program. These revised and uniformly organized sections then were presented to the Governor's Advisory Committee on Mental Retardation in January, 1966.

With the exception of the report on Organization and Coordination, the *Preliminary Draft of the Texas Plan to Combat Mental Retardation* was approved by the Governor's Advisory Committee. An Executive Committee, appointed by Judge Jones and chaired by Dr. Peck was authorized to rewrite the report of the Task Force on Organization and Coordination and to edit the approved draft.

This Executive Committee met on January 30, 1966, and completed the final work on the *Recommendations for the Development of the Texas Plan to Combat Mental Retardation.* The report then was given to the Planning Office for printing in preparation for the Governor's Conference on Mental Retardation.

FINAL PLANNING PHASE: THE GOVERNOR'S CONFERENCE

The culmination of all planning activities to determine what action is needed to combat mental retardation in Texas and what resources are available or needed for this purpose came in a one-and-a-half day Conference on Mental Retardation called by Governor John Connally for March 17-18, 1966. At this meeting the *Recommendations for the Development of the Texas Plan to Combat Mental Retardation* were to be presented to the Governor, the Interagency Committee, and the people. Everyone who participated in the planning project throughout the State was invited to attend. Also invited were members of the Interagency Committee, the Governor's Advisory Committee, the State Agency Planning Committees, the State Task Forces, the Mayors' Commissions, and many other interested citizens.

From the *Recommendations for the Development of the Texas Plan to Combat Mental Retardation,* the Interagency Committee prepared this official *Texas Plan to Combat Mental Retardation.*

Success of the Planning Study is a tribute to the leadership of Governor John Connally, the Governor's Advisory Committee, the Interagency Committee, and the active interest and participation of the members of the Mayors' Commissions, organizations such as TARC, and the thousands of Texans who comprise the "Society of the Concerned."

LOOKING AHEAD

Planning and action must go together. The Texas Mental Retardation Planning Study staff now becomes the implementation staff under a $223,000 Federal implementation grant awarded to Texas. The real effort to combat mental retardation is just beginning. As a result of this initial planning effort, a true social movement exists in its crescive stage focused upon the objective of combatting mental retardation in all its forms. The success of the initial effort must not be lost but must be used as the basis for an expanded program of implementation, coupled with the development of adequate information and coordination of resources, needs, and personnel in this long-neglected area of health, education, and welfare service.

2. THE ROLE OF HEALTH SERVICES

INTRODUCTION

The full range of health services for the mentally retarded will, of necessity, cover a broad spectrum of health activities including prevention, diagnosis, evaluation, treatment, rehabilitation, and overall care. These health services will be carried out at different levels and ultimately will require the coordinated effort of individual, community, regional, State, and Federal action. The prime goal of these coordinated health efforts, however, must always be the provision of a continuity of services for the retarded when and where required. Highly specialized health facilities at regional, State, and local levels for work with the retarded should be developed. Existing facilities and programs should be coordinated or merged with new programs.

In addition to health programs geared to the special needs of the retarded, much can and must be provided as a routine and integrated part of the daily health activities of now existing agencies and programs. Gaps in State, community, and local health services must be bridged. These programs, serving large segments of the population, should be made immediately available to the mentally retarded. Public health programs in the area of prevention, amelioration, maternal health, health education, school health, well child conferences, and many other health activities must be available to the mentally retarded.

Regional centers and specialized State institutions can and will play a significant role in providing health services and health leadership for the mentally retarded. It is mandatory, however, that each community play a major role in providing its part of the continuity of care needed to adequately meet the problems of the retarded. In short, better and more comprehensive programs of health services for the total child and adult population, regardless of condition or severity, should be the aim of all health programs. When this goal is pursued, a large portion of the health needs of the retarded will be met. The extension of such health services in conjunction with specially developed facilities will be the most effective method of meeting the total health needs of the retarded.

This goal can be realized only if the services of many professions, agencies, and programs are correlated. It is recognized that use of existing concepts and development of new concepts of interdisciplinary, interagency, and intercommunity responsibility are essential for the success of this goal. Inherent in the philosophy of providing health services for the retarded is the core concept of needing to mobilize local, community, and State resources to meet the health needs of the total population.

In this way, health programs for the retarded will become an integral part of the health services available to all citizens, and the development of specialized facilities can take place free of the need for meeting the obligations best discharged by existing programs. Retarded persons need the health services required by all people, with the addition of specialized services to meet their own unique needs.

SCOPE OF PROBLEM

The total scope of the problem of health services for the mentally retarded in Texas is unknown. Main aspects of the problem are: Not knowing how many retardates there are in the State; finding ways to provide services for those who are known; and determining the various causes of mental retardation. Some known facts are available and are supplemented by percentages and estimates.

Although the exact number of retardates in the State is not known, approximately 11,500 are enrolled in the six State Schools; approximately 27,236 are enrolled in special education classes in public schools; those cared for in child care facilities probably total fewer than 500. However, the number of undiagnosed retardates who are kept at home, out of society, is not known. The question also arises whether some children classified as retarded have actually been properly diagnosed.

Using accepted percentages in estimating the mildly (2.5%), moderately (.4%), and severely (.1%) retarded and the estimated 1964 population of Texas (10,230,209), the following figures indicate the number of these groups in the State:

Mildly retarded	255,755
Moderately retarded	40,520
Severely retarded	10,230
TOTAL	306,505

Of the 254 counties in Texas, only 64 counties contain 73 per cent of the State's population. This would indicate that approximately 27 per cent, or 82,756, of the retarded persons in the state reside in 190 counties.

Ninety-nine counties in Texas have a population of less than 10,000:

Population	Number of Counties
Less than 1,000	3
1,000– 3,000	23
3,000– 5,000	21
5,000– 7,000	22
7,000–10,000	30

(See map on next page)

Realizing the vast areas which are sparsely populated and the low income which they would have, it is understandable why health services are not readily available.

There are about 240,000 live births per year in Texas. The use of an incidence factor of 3 per cent of the total population indicates 7,200 of these children, each year, will be mentally retarded.

How does mental retardation compare with other handicapping conditions? Nationally, it afflicts twice as many individuals as blindness, polio, cerebral palsy, and rheumatic heart disease combined. The estimated cost of life-time care for a mentally retarded person in a State institution is $100,000.

What brings about or causes mental retardation? What preventive measures can be taken? There are numerous causes, including maternal conditions, metabolic disorder, and accidental brain damage; however, many causes of mental retardation remain unknown and some are not well understood. Research continues to progress. Methods for preventing a number of these causes have been found. Research in some instances has progressed so rapidly that those who are in a position to put the research findings into practice have not been able to do so. Recognizing that much can be accomplished, more prevention and detection practices are being carried out in the fields of full health services for all children as well as those affected by this condition.

WHAT IS BEING DONE

Prevention of mental retardation is the ultimate goal and best hope since it has been stated by authorities that one-half of the future cases of mental retardation could be prevented if present scientific knowledge were used in current practice. To survey what is being done by health services one must face realistically the shortage of qualified medical and paramedical personnel in Texas. This is a very complex picture throughout the United States and one which requires a multi-pronged attack with money and resources far beyond that which has been expended previously if adequate services are to be provided.

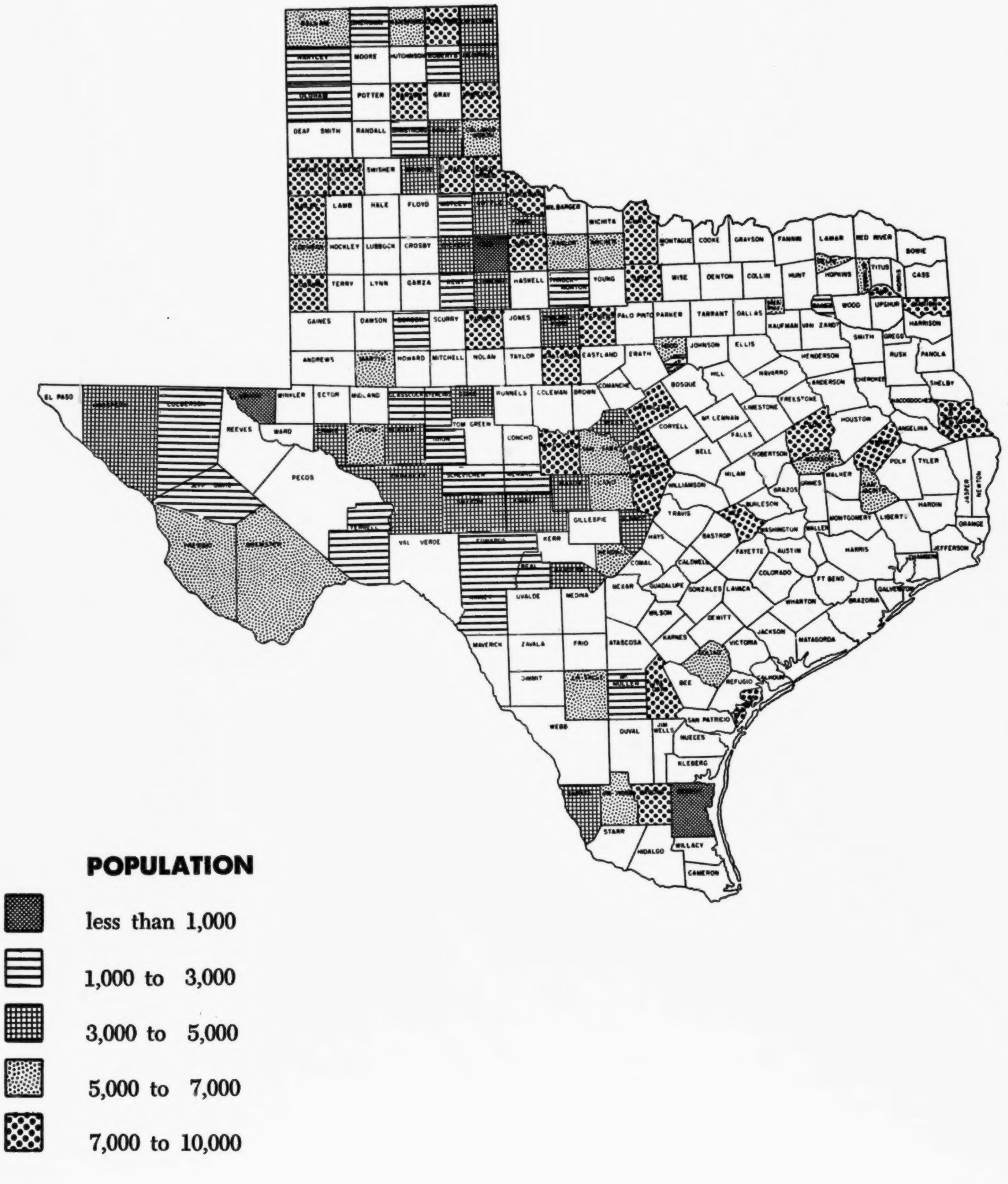
Texas, with an estimated population of 10,230,209 in 1964, has one local health officer in each of the 254 counties whose responsibility is the general supervision of the health of the public under his jurisdiction. Most of the county health officers are part-time local general practitioners with very limited time to devote to this public service, or retired physicians with little incentive for the work. Preventive health services are available through the Texas State Department of Health and 60 local health departments serving 69 counties.

MATERNITY SERVICES

Since prenatal service is a vital factor in prevention of mental retardation and must be improved at all levels, it is important to review facilities and resources available in this area.

TEXAS COUNTIES WITH LESS THAN 10,000 POPULATION

(1960 Census)


MOORE
HUTCHINSON
POTTER
GRAY
DEAF SMITH
RANDALL
SWISHER
LAMB
HALE
FLOYD
HOCKLEY
LUBBOCK
CROSBY
TERRY
LYNN
GARZA
WILBARGER
WICHITA
HASKELL
YOUNG
MONTAGUE
COOKE
GRAYSON
FANNIN
LAMAR
RED RIVER
BOWIE
HOPKINS
TITUS
CASS
WISE
DENTON
COLLIN
HUNT
WOOD
UPSHUR
HARRISON
GAINES
DAWSON
SCURRY
JONES
PALO PINTO
PARKER
TARRANT
DALLAS
KAUFMAN
VAN ZANDT
SMITH
GREGG
ANDREWS
HOWARD
MITCHELL
NOLAN
TAYLOR
EASTLAND
ERATH
JOHNSON
ELLIS
HENDERSON
RUSK
PANOLA
EL PASO
CULBERSON
WINKLER
ECTOR
MIDLAND
GLASSCOCK
RUNNELS
COLEMAN
BROWN
COMANCHE
BOSQUE
HILL
NAVARRO
ANDERSON
CHEROKEE
SHELBY
REEVES
WARD
TOM GREEN
CONCHO
CORYELL
MC LENNAN
LIMESTONE
FREESTONE
HOUSTON
NACOGDOCHES
ANGELINA
PECOS
BELL
FALLS
ROBERTSON
MILAM
WALKER
POLK
TYLER
JEFF DAVIS
SCHLEICHER
WILLIAMSON
BRAZOS
GRIMES
BURLESON
JASPER
NEWTON
HARDIN
GILLESPIE
TRAVIS
WASHINGTON
WALLER
MONTGOMERY
LIBERTY
ORANGE
TERRELL
VAL VERDE
EDWARDS
KERR
HAYS
BASTROP
FAYETTE
AUSTIN
HARRIS
JEFFERSON
CHAMBERS
COMAL
CALDWELL
COLORADO
FT BEND
UVALDE
MEDINA
BEXAR
GUADALUPE
GONZALES
LAVACA
WHARTON
BRAZORIA
GALVESTON
WILSON
DEWITT
JACKSON
MATAGORDA
MAVERICK
ZAVALA
FRIO
ATASCOSA
KARNES
VICTORIA
GOLIAD
DIMMIT
MC MULLEN
BEE
REFUGIO
CALHOUN
WEBB
DUVAL
JIM WELLS
SAN PATRICIO
NUECES
KLEBERG
STARR
HIDALGO
WILLACY
CAMERON
POPULATION
less than 1,000
1,000 to 3,000
3,000 to 5,000
5,000 to 7,000
7,000 to 10,000

PRENATAL CARE

Analysis of birth certificates in relation to prenatal care for 1963 in Texas indicates that live births totaled 239,016, and 19,710 of these (8 per cent) were premature births.

Prenatal Care	*Total Births*	*Prematures*
Unstated	2.0%	13.4%
None	7.0	2.9
Month not stated but did have some care	1.9	1.9
Began prenatal care:		
1st month	5.9	5.4
2nd month	22.9	19.8
3rd month	27.0	22.8
4th month	11.7	11.5
5th month	7.0	7.5
6th month	5.3	5.8
7th month	4.5	4.6
8th month	3.3	3.2
9th month	1.3	1.4

Analysis of this data shows that 3.4 months was the median at which expectant mothers first sought prenatal care, while the percentage of mothers delivering without any prenatal care at all and those seeking care late in pregnancy was dangerously high.

There are only 683 obstetricians and 3,366 general practitioners available to provide maternity services. Approximately 520 midwives provide far less than adequate prenatal information to expectant mothers even though they perform 4.2 per cent of the total deliveries in Texas. The midwife is usually limited in formal education and often totally unaware of the danger she can cause through the mishandling of mother and infant. In areas where the services of physicians are unavailable or where cultural groups demand, the midwife becomes a necessity. The solution to this problem appears to be the professional nurse-midwife.

The shortage of nurses is well known in spite of the fact that there are more nurses working today than ever before. Though there are approximately 17,222 registered professional nurses in Texas actively employed, there are more vacancies for nursing positions than ever before. To meet this shortage, less qualified personnel such as vocational nurses and nurses aides have been added in hospitals and nursing services. In 1962 the American Hospital Association reported a ratio of registered professional nurses to licensed vocational nurses of 2.9:1. In Texas the ratio is 1.5:1. It is further shown that for every hour of nursing care provided by registered nurses in general and special hospitals, three hours are given by nursing personnel with less preparation.

Outpatient clinic services are provided in 144 hospitals and by 27 local health departments operating 82 maternity conferences. At first glance these statistics appear to show that a very adequate prenatal supervision program is provided for mothers in Texas. Other important facts reveal shortages of other key health personnel when compared with the ratio of public health personnel to the population as recommended by the American Public Health Association.

Discipline	*APHA Recommended Standards*	*Texas Situation*
Physicians	1:50,000	1:200,000
Nurses	1:5,000	1:7,000
Dentists	1:70,000	1:400,000
Health Educators	1:50,000	1:600,000
Sanitarians	1:15,000	1:20,000
Clerks	1:15,000	1:20,000

DELIVERY SERVICES

Referring again to the study of the 1963 birth certificates it is observed that 95 per cent of deliveries were in hospitals and 95.9 per cent of all deliveries were attended by physicians. However, approximately 12,000 mothers failed to avail themselves of the services of a physician or the hospital. This means educational programs for all socio-economic levels must be strengthened to help expectant parents to recognize the importance of seeking prenatal supervision as soon as the mother is aware that she is pregnant.

INFANT AND CHILD HEALTH SERVICES

Infant and Child Health Services are provided predominantly through family physicians who are general practitioners, and less through pediatricians. There are approximately 450 pediatricians and 3,366 general practitioners in Texas for services to infants and children.

One of the important preventive services in mental retardation programs was started by the Texas State Department of Health when the voluntary program of screening newborns for phenylketonuria (PKU) began in September, 1963. This program continued until August 31, 1965. During this period

66,961 PKU tests were performed, from which five cases were detected. The law enacted by the 59th Legislature requiring persons attending a delivery of an infant to subject the infant to a test for phenylketonuria reasonably assures the early detection and possible prevention of this form of mental retardation.

PREMATURE SERVICES

Review of total births for 1963 in Texas shows that 8 per cent were premature and that 3.7 was the median month of gestation in which these mothers sought prenatal care. Education of these mothers, urging them to seek early prenatal care, may influence markedly this incidence of prematurity. Services for the care of these infants are provided by local community hospitals, primarily in the metropolitan cities and larger towns. More recently hospitals in some of the smaller towns are expanding facilities and acquiring equipment for the care of the larger premature infant. It is to be desired that the very small premature be cared for in the intensive care premature nurseries in the larger hospitals. Nursing care of these infants is a great problem because of the shortage of nurses with special training in care of the premature. Follow-up care of prematures is provided through special clinics until the infant reaches the regular well child conference developmental level.

WELL CHILD SUPERVISION

In addition to services which are provided by family physicians and pediatricians, through private practice and through outpatient clinic services of community hospitals, 38 local health departments in Texas operate 239 well child conferences for infants and preschool children. These conferences provide medical examinations to determine normal growth and development, and discover defects and deviations from the normal; immunizations for prevention of certain communicable diseases; public health nursing services which include instruction for mothers; and supervision for follow-up care needed in the homes. Nutritional instruction is given mothers regarding feeding of the entire family as well as infant feeding.

SCHOOL HEALTH

Of the independent school districts in Texas, 1,475 districts employ the following health personnel: Medical Directors, 10; dentists, 0; nurse directors, 5; nurse supervisors, 17; staff nurses, 778; health, physical education and recreation supervisors, 30.

All but 74 of the 254 counties in Texas have one or more school nurses. Range of services provided by these staffs include screening for defects and deviations from the normal; medical examinations followed by referral for follow-up services to family physician, dentist, or to other appropriate community services; and consultation on health matters with other school personnel and parents.

SERVICES TO MIGRANTS

Another group for whom special services are needed are 129,000 migrants who claim Texas as their home or who seasonally are visitors in Texas from other states. The number of mentally retarded among migrant families is not known, but applying the same percentage as applied to the general population it is realized, then, that services for these possible 3,870 mentally retarded persons should be available.

FAMILY PLANNING SERVICES

Family planning services are available through family physicians and attending obstetricians, the Planned Parenthood Association clinics located in 15 Texas cities, and the clinics administered by one local health department. These are not sufficient to take care of the parents needing this service. According to figures from the Regional Office of Planned Parenthood–World Population, the following relates to Texas:

1. Total Population—1960 Census	9,579,023
2. Number of Medically Dependent Females of Child Bearing Age	216,807
3. Number of Married Women in Need of Contraceptive Service	98,655
4. All Women (Married and Single) of Child Bearing Age, Fertile and in Need of Contraceptive Service	156,000
5. New Patients Served	12,160
6. Old Patients Served	9,740
7. Total (New and Old) Patients Served	21,900
8. Per cent of No. 3 (above) Served	22.2%
9. Per cent of No. 4 (above) Served	14.0%

MENTAL HEALTH AND MENTAL RETARDATION

The Texas Department of Mental Health and Mental Retardation, created by the 59th Legislature, administers 29 institutions (as of September 1, 1965). Of this number, 6 are hospitals for treatment of acute mental illness, 4 for the care of aged psychotic patients, 11 for outpatient clinic services to patients not requiring total hospitalization; and 6 are Special Schools for training, supervision and care of mentally retarded persons. State Schools for the Mentally Retarded are located in Abilene, Austin (Austin State School and Travis State School), Denton, Lufkin and Mexia.

Clinic Evaluation Services for the Mentally Retarded and the Multiple-Handicapped are provided through the following:

1. Child Study Center, Inc. .... Fort Worth
2. The Diagnostic and Evaluation Center, Denton State School .... Denton
3. Gulf Bend Center for Children and Youth .... Victoria
4. Mental Evaluation Clinic, Junior League Outpatient Department, Texas Children's Hospital .... Houston
5. The Austin Evaluation Center, Inc. (Not ready for operation at this writing, but in the process of recruiting personnel for staff) .... Austin
6. Child Development Center, The University of Texas Medical Branch .... Galveston

Other services for the Mentally Retarded may be secured through the Division of Maternal and Child Health, Texas State Department of Health, and through the Texas Association for Retarded Children, a voluntary, parent-inspired association. Additional services are provided by very active on-going study and action committees of professional organizations, health and allied disciplines.

HEALTH SERVICES—DENTISTRY

The need for dental service for mentally retarded persons is an unknown quality. However, some generalizations can be made from information available from various sources.

Snyder[1] stated that in a study of 113 non-institutionalized handicapped children, only 3 per cent of needed dental work had been accomplished as opposed to 50 per cent for the normal population. Poor oral hygiene and periodontal disease are the most serious problems for the mental retardate.[2] Lozano[3] estimated that the average mentally retarded child entering a State Special School requires immediate treatment for 13 teeth. The most pressing problem is a high incidence of periodontal involvement and a high prevalence of carious teeth due to the inability of the patient to help himself. This is amplified by the conspicuous absence of routine dental services.[4]

Dental Services available to the mentally retarded person can be divided into two groups: (1) Service for non-institutionalized private patients, and (2) services for residents of State custodial institutions.

NON-INSTITUTIONALIZED RETARDATES

The dental service being obtained by mentally retarded persons in the private practice situation can only be estimated. If Snyder's study is applicable to Texas, it is quite apparent that this need is not being met. Conjecture leads to conclusions that either the parents are not seeking care, the dentists are not providing the care, or both. In one study[5] of 52 dentists, 70 per cent responded that they provided dental service for both severely and moderately retarded children.

It is of interest to note that in Georgia,[6] 90 per cent of the handicapped children are only mildly retarded. Projecting this figure to Texas, approximately 270,000 retarded persons (90 per cent of 300,000) can be considered as routine dental patients capable of being treated in general practice offices.

The Texas State Board of Dental Examiners in 1963 listed 3,481 dentists licensed in Texas with approximately 3,000 available to the population at large. The 1964 dentist population ratio for Texas[7] is 1:2708 as compared with a national ratio[8] of 1:1712 and a suggested ideal ratio of 1:1500 (American Dental Association). This ratio varies geographically as the heavily populated areas exhibit a lower ratio. Four counties have 47.9 per cent of the State's total number of dentists. Forty-four counties in Texas have no dentist available. Only 368 dental hygienists were licensed as of September, 1964.

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[1] Snyder, J. R., Judith Knopp, and W. A. Jordan. *Dental Problems of Non-institutionalized Mentally Retarded Children.* Northwest. Dent., 39:123-133, 1960; 41:11-15, 1962.

[2] Cohen, M. M. *Periodontal Disturbances in Mental Retardation.* Proceedings of the workshop on dentistry for the handicapped, pp. 30-37. Philadelphia, University of Pennsylvania School of Dentistry, 1958. (121 pp.)

[3] Lozano, Carlos, personal communication.

[4] Wilson, John, personal communication.

[5] *Guidelines for State Task Forces on Mental Retardation Planning,* p. H-4.

[6] Wilson, John, Op. Cit.

The 10 per cent level (30,000) classified as moderately or severely retarded[9] would probably require dental service from a specialty practice. Since more than 11,000 are residents of State Special Schools some 19,000 would be seeking the services of dentists who are specialists in pedodontics. The Texas State Board of Dental Examiners listed 74 of these specialists in 1963. This produces, therefore, a ratio of specialists to moderately or severely retarded children of 1:270. The majority of these specialists are located in heavily populated areas of the State.

STATE SPECIAL SCHOOLS

Six State Schools provide dental service for the mentally retarded. The table below shows location of the State Schools, resident populations, number of dentists employed (some part-time), dentist population ratio and number of ancillary dental personnel (information as of November, 1965).

All dental services are available in the State Schools with the exception of most of the specialty services. (Consultative oral surgery service is the only specialty service available.) It is presumed that a majority of these State School residents would require a dentist with specialty training in order to receive adequate treatment.

An inspection of the dental service for the Board for Texas State Hospitals and Special Schools (now the Texas Department of Mental Health and Mental Retardation) was undertaken in 1962-63. The inspection team noted the following: (1) Physical size and space planning of the clinics was poor; (2) equipment for proper sterilization of injection and surgical instruments was inadequate; (3) in-service continuing education programs for staff dentists were nonexistent; (4) pay scale for the dentists was less than that for medical personnel of comparable seniority or grade; and (5) there was no overall dental director to coordinate and supervise the various dental treatment programs of the State Schools. One might summarize by noting that the Special School Dental Clinics are under equipped, understaffed, underpaid, and lack the specialty services.

Actions needed to improve the situation for non-institutionalized retarded persons would include: (1) Increase the number of dentists and dental hygienists in Texas; (2) Use dental hygienists at Mental Evaluation Centers as Dental Health Consultants to parents of mentally retarded children; and (3) Increase the emphasis on continuing education for practicing dentists, particularly regarding the dental needs of mentally retarded children.

TABLE: DENTAL SERVICES IN TEXAS SPECIAL SCHOOLS, 1965

State School	*Resident Population*	*Dentists*	*Ratio of Dentists (DDS) to Population*	*Dental Hygienists*	*Dental Assistants*
Abilene	2243	2	1:1121	0	1
Austin	2459	1½	1:1640	1	2
Denton	1738	0*	1:1738	1	1
Lufkin	388	½	1:776	0	1
Mexia	2738	2	1:1369	1	2
Travis	1864	1	1:1864	1	1

*The Denton State School recently affiliated with Baylor University School of Dentistry, Dallas, to provide dental service in conjunction with a teaching program for the graduate students in the Department of Pedodontics. This program provides an equivalent full-time dentist.

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[7] *Distribution of Dentists in the United States by State, Region, District, and County*, American Dental Association, 1965.

[8] Ibid.

[9] Wilson, John, Op. Cit.

Actions needed to improve the situation for retarded persons in the State Schools would include: (1) Employment of dental hygienists and other ancillary personnel to institute effective preventive dental programs (oral hygiene teaching and supervision, topical fluoride treatments, dietary counseling, and extra-dietary fluoride programs); (2) emphasis on a continuing education program for institutional dental personnel; (3) institution of pay scales for dental staff comparable to those for the medical staff.

WHAT SHOULD BE DONE?

In recent years new medical discoveries have generated fresh optimism and renewed efforts in case-finding, diagnosis, treatment, and habilitative techniques for many problems affecting mankind. With each advance there has resulted an improved knowledge of preventive measures through which lowered incidence and even eradication of specific conditions can be brought about.

Mental retardation is a symptom manifested by a limitation in functional characteristics, impairments in intellectual functioning, and social adaptations of the individual. Vigorous and effective application of present knowledge can significantly reduce the occurrence of mental retardation. The high incidence of causative factors and enormous cost of a lifetime of care for each retarded person justify—on economic grounds alone—the expenditure of large sums for prevention. It is recognized that many preventive measures are overlapping in their benefits to the total health of mankind; therefore, the expansion and improvement in quality of such preventive services should not be considered from a singular viewpoint.

Optimum application of health services requires that all such services join together in a logical progression and that the retarded individual be integrated, within the limit of his capabilites, into normal society. Greater emphasis should be placed on the prevention of mental retardation and the promotion of social-emotional and physical health in health services for mothers and children. The latter implies a need for making updated information available to all medical practitioners and allied health workers, and an even greater need for recognition by individuals of their responsibility to utilize the scientific knowledge and services available.

There are three broad fronts on which prevention of mental retardation can be pursued. These deal with the problem from the biological, psychogenic and socio-cultural aspects. Thus, it is essential that health services be directed toward:

1. Prevention of the occurrence of retardation through application of preventive measures against each causative factor as rapidly as such is recognized.

2. Early diagnosis and treatment (including rehabilitation) that may modify or reverse the course of the disease.

3. Prevention of handicaps likely to superimpose themselves on the retarded person.

4. Diagnosis and treatment (including rehabilitation) as early as possible, of those handicaps that have superimposed themselves on the retardate.

Implementation of these principles requires an awareness and alertness on the part of physicians, nurses, social workers, teachers, psychologists, and other paramedical specialists; utilization of all existing services with expansion of such services as necessary to meet the total need; expansion of research to pinpoint better the causative factors and to develop practical every-day application of new findings to the areas of prevention, diagnosis, treatment, and rehabilitation; development of diagnostic and evaluation centers; and development of area hospitals for those retardates requiring institutionalization.

PREVENTION

Biological Aspects: Biological prevention offers great opportunities through application of existing and newly acquired knowledge to every expectant mother and newborn infant.

It is essential that expectant mothers receive adequate prenatal care beginning early in pregnancy in order that maternal conditions (metabolic or endocrinologic disorders, infections, genetic factors, and physical conditions) may be recognized and proper therapeutic measures instituted, and to prevent complications of pregnancy. The objectives, in addition to preventing maternal morbidity and mortality, are: (1) Prevention of damage to the fetus during pregnancy; (2) prevention of premature births; and (3) prevention of damage to the infant at time of birth.

Much progress has been made toward getting expectant mothers to avail themselves of medical knowledge and skills during pregnancy and at the time of delivery. Prenatal care has been made available to many of those in the economically deprived segments of the population through community health services. However, in spite of the fact that a physician is in attendance at approximately 96 per cent of all deliveries in Texas, more than 21 per cent of these women who deliver each year failed to seek medical supervision until after the fifth month of pregnancy.

Each local community should evaluate carefully and periodically the statistical data pertaining to its births in order to determine the community's needs. Data for small geographical areas of large communities should be utilized so as to best determine the segment or segments of the population not receiving adequate prenatal, natal and postnatal care; such data may be kept by census tract. In addition to a thorough analysis of statistical data, the community evaluation should include a determination of the availability of service to all segments of its population, adequacy of facilities used, utilization of the services, and the quality of care available. Serious consideration should be given to those facilities provided for the disadvantaged, particularly as to adequacy of number available to meet the total needs and as regards accessibility to those needing the services.

Each community needs to evaluate its facilities, as regards number and quality of care, for delivery of mothers; utilization of the facilities especially from the viewpoint as to the segment of the population not using them; provisions for care of newborns with particular emphasis on care available for premature infants; and the extent and completeness of referral to the public health nurse of those mothers and infants identified as needing follow-up after discharge from the hospital. Particular attention should be given to the availability and utilization of a coordinated program for prematures.

Adequate laboratory services should be available to physicians, maternal and child health centers, and to hospitals. For the more highly technical tests, arrangements should be made to have such available even though it might be best that they be performed in regional laboratories.

Community health services for postpartum examination and care of mothers and for health supervision of infants should be available and should include provisions for follow-up by public health nurses of those not availing themselves of such services. The most powerful weapon at hand is the provision of easily accessible child health supervision of a standard which approaches that outlined in the manual, "Health Supervision of Young Children," of the American Public Health Association.

Better understanding of genetically determined enzymatic diseases in which inborn errors of metabolism allow toxic substances which cause severe damage to the brain to accumulate in the body has opened a new horizon to preventive possibilities.

The 59th Texas Legislature in 1965 passed a law requiring phenylketonuria (PKU) testing of every newborn infant. Every support should be given to assure that such testing is successfully carried out, and to assure that no suspected case is lost to medical supervision due to lack of knowledge or unconcern on the part of the parents. The Texas State Board of Health should review developing knowledge in order to declare periodically which test or tests will be considered as acceptable.

Throughout all aspects of prenatal, natal, and postnatal care, there should be close coordination between the health personnel involved. Knowledge of home environment and family conditions should be correlated with the physician handling the specific case. In those cases requiring follow-up, the physician should correlate his information with the personnel responsible for the follow-up so as to permit such to be of the best quality possible.

Past experience shows, however, that it is not enough to have preventive tools available. It has been frequently observed that those who stand most in need of services are in fact those who seek and utilize them least. A considerable amount of health education directed to personal motivation in their acceptance and use is necessary. In addition, health education should be directed toward prevention of diseases, particularly those for which vaccines are readily available. Health education in the area of safety should also be stressed in order to reduce the incidence of injuries, especially those of the head, and the incidence of poisonings.

Professional workers need to be provided opportunities in the form of formal courses or meetings and staff meetings or refresher courses. All professionals should be kept up-to-date on techniques and methodologies in current use and under study. New knowledge should be made available to each professional worker as soon as possible. Each physician and nurse working with infants and children should be kept acquainted with the behavioral and developmental inventory of infants and young children.

It is recognized that the key individual in the health services described is the physician. To supplement the services of the physician in charge of any individual problem case, to provide general preventive programs for the economically disadvantaged, and to correlate total health education of the community there are 60 full-time local health departments, affiliated with the Texas State Department of Health, which are responsible for service to the entire population they serve. These local departments serve 69 counties of the 254 in the State; approximately 75 per cent of the State's population is thus served.

Obviously, the extent of services provided by any one department is basically dependent upon the amount of local financial support it receives. Each community should be more aware of its total health needs and recognize its obligations to meet them to the best of its ability. State and local officials should intensify their efforts to promote the establishment of additional full-time local health departments. The State should supply funds to supplement local funds in order to assure good quality health services.

Health education should be recognized as a basic program of each such department and should be expanded to the level whereby it reaches the entire population served, and not be limited to the old concept that "every public health worker is a health educator." The latter is true, but results in health knowledge reaching too few people in a piecemeal basis when a total health education program is lacking.

Psychogenic and Socio-Cultural Aspects: The concept of psychogenically-based retardation is generally accepted, and the origins of such retardation may be from conditions in the environmental aspect or conditions within the individual, or both.

All workers with children, especially infants, need to keep abreast of clinical and experimental research regarding the individual's need for sufficient and appropriate stimulation in order to develop an adequate mental capacity. Further knowledge is needed to pinpoint appropriate stimuli for proper age levels, and to determine the best approaches to reversing mental retardation due to such causes.

Use of foster homes, rather than institutions, for the care of infants and children needing such care is commendable and should be encouraged. Where it is necessary for working mothers to place infants and children in day care centers, it is essential that they be selective in choice of such centers. Foster parents, institutional workers, and workers in child-care centers need to be made aware of child behavior and development patterns of children. Inspectors of foster homes and child-care centers need to place more emphasis on these aspects.

Parents need to become more aware of the needs of children, and to better relate themselves to the child. This should not be interpreted as encouraging over-protection of the child; over-protection can be as damaging as passivity or lethargy.

DIAGNOSIS, EVALUATION, TREATMENT

Identification and diagnosis of mental retardation can be one of the most challenging problems to confront the physician who first sees the infant following delivery. It is the physician who has the first opportunity to make the parents realize that medical interest in the child is a continuous process, and not one that is limited to those periods of life when the child is ill.

With exception of those few instances where mental retardation is apparent from the first, it is the physician, by careful observation and recording of growth and development of the child, who is in the best position to suspect deviation from the normal range and to initiate additional diagnostic procedures. The physician also has a most important role in continued supervision, guidance, and support for the child and parents, assessment and determination of activities best suited for comprehensive care and treatment, and coordination of community resources, that may be brought into play, from the standpoint of the individual retardate.

Mothers of retarded children need to be seen periodically, just like mothers of normal children. All mothers need to have their questions answered, to be told about feeding, development and behavior, immunizations, and all the other points that concern mothers. In instances of mental retardation, the father needs explanations and help to accept the situation and to be supportive to the mother.

The mentally retarded child is more susceptible to illness; thus, there needs to be close follow-up of his physical condition. Mentally retarded children may have dental, nutritional, orthopedic, hearing, and/or speech problems, and need to have such problems recognized as early as possible. Correction of handicaps, which superimpose themselves on the mentally retarded child, can often increase the child's total functional capacity.

It is recognized that mental retardation may result, at any age, from bacterial infections affecting the brain directly or secondarily as complications of such infections elsewhere in the body; head trauma from accidents, prolonged febrile seizures with asphyxia, and poisonings. The physician is in the best position to recognize that mental retardation may be a final result of such conditions and to utilize techniques and knowledge aimed at preventing or modifying such results. In spite of everything possible being done, there will be a number of cases of mental retardation resulting from such causes. Early recognition of retardation, evaluation of the individual's capabilities, family guidance and support, and coordination of community resources are as important in caring for those who become retarded at a later period in life as for those cases recognized in infancy.

Diagnostic and Evaluation Centers: Although the primary physician may strongly suspect mental retardation, he may need or desire the consultative services of other medical and paramedical specialists and a wide variety of laboratory tests to better establish the diagnosis and to determine, after evaluation of the total individual, those measures best suited for the individual case. The importance of utilizing interprofessional consultants is further borne out by the fact that a person who seems retarded may be suffering from defective hearing or vision, cerebral palsy, communication or speech disorder, emotional disorder, malnutrition, or another chronic illness.

To assist the primary physician in his diagnosis and evaluation of the suspect case, there is need for the establishment of Diagnostic and Evaluation Centers where professionals of diverse technical components are concentrated and have available all necessary testing techniques and laboratory facilities.

It is felt that the Diagnostic and Evaluation Centers should be available to all handicapped children on a fee basis according to the ability of the parents to pay for such services. A statewide plan to assist parents, especially those who are economically deprived, to obtain the services of such centers is urgently needed. Such a plan could be established in accordance with procedures used in the Crippled Children's Program.

Diagnostic and Evalution Centers should be located in sufficient numbers throughout Texas so as to be available to all areas of the State. A basic consideration for the establishment of such centers should be the provision of needed professionals (pediatricians, psychiatrists, neurologists, psychologists, etc.) and the necessary testing and laboratory facilities. Provisions should be made to assist parents to accompany children referred to such centers, and such assistance should include expenses for travel, board and room while the child is at the center. The experiences gained in the State Congenital Cardiac Program could be used to establish procedures.

It is further felt that a Diagnostic and Evaluation Center should be established in the area of each medical school located in the State, and that these centers should include the professional and procedural research so vitally needed. These centers should provide consultative services to other centers not so located, and should periodically make known new research findings, especially evaluations of procedural research, so that all centers may operate at the highest professional level possible.

Diagnostic and Evaluation Centers should provide the necessary link with the communities they serve. Referring physicians should be kept fully apprised of their respective cases, and there should be full utilization of those health services available in the home community. Conversely, the primary physician and the community resources brought into play should keep the Center apprised of the retarded person's progress.

A decision needs to be made concerning whether or not the specialized centers should include services for all chronic handicapping conditions, including cerebral palsy, congenital malformations, epilepsy and multiple handicaps. Continued fragmentation of services by specific entities can only result in excessive costs and lowered efficiency of services for the total individual needing help, as well as confusion to parents who are already confused and who are seeking professional help.

Institutional Care: No type of retardation is in itself an indication for residential care, but such care is appropriate for severely retarded patients who require a degree of physical care which their families are unable to provide.

The type of institution used for any particular patient is a decision to be resolved through the evaluative process discussed above. The retarded person may be placed in: (1) Tax supported or privately sponsored facilities called hospitals, schools, colonies, or homes; (2) general, mental, or special hospitals; or (3) halfway houses, boarding, nursing, or foster homes.

The accepted solution today favors smaller facilities rather than large hospital-type institutions. The concept calls for the establishment of such facilities at multiple locations in the State—a regional concept having patients closer to home rather than in a large facility requiring families to travel great distances or to forego ever visiting the patient.

The regional-type facility should provide optimum opportunities for education to all residents. The staff should be oriented toward full development of the individual and not concerned merely with his physical well-being. The institution should be integrated as closely as possible with appropriate community activities with a view of providing each individual with maximum opportunity for personal development. The objective should be to return as many patients as possible to their homes.

There should be a plan of operation whereby the family, primary physician, diagnostic and evaluation center where the individual was first seen, and the health services of the home residence are kept aware of the retarded person's progress. Planning for return home of any patient should be sufficient to allow for a fluid transition from one environment to another.

Research on motivation, learning, memory, retention of skills, and attitudes toward self and society on the part of the retarded person is sorely needed. This research should be conducted by the regional, hospital-type facilities, and usable information should be passed on to all professionals working in the field of retardation. Techniques developed should be exchanged with the staffs of diagnostic and evaluation centers, and with special education teachers, for use in evaluation studies and decision-making as regards future patients.

Communities should be encouraged to establish facilities at home for retarded persons not requiring the close supervision available at the regional facility. Much attention needs to be given to assure the day care center, boarding, nursing or foster home provides the desired opportunity of meeting the educational, vocational, and recreational needs of the retarded.

EDUCATION

There is need for improved awareness on the part of the general public toward the overall needs of the handicapped, especially the mentally retarded. This should be accomplished through education of the average taxpayer, if all the recognized needs are to be satisfactorily met. A better public understanding of the known causes of mental retardation will result in: (1) Removal of erroneous concepts which now exist; (2) prevention of guilt complexes in parents of retarded children; (3) improved awareness that retarded persons have potentialities that need to be developed; (4) awareness of the total needs of the retarded; (5) an improved application of known preventive measures.

Students of medicine, nursing and other allied health fields need to know more about the complexities of mental retardation. Such teaching needs to be supplemented by education in the effects of psychological, social, and cultural factors on individual development, as well as the developmental and behavioral patterns of individuals. Such teaching should be integrated into the various departments and disciplines inside, as well as those utilized from outside, the schools.

Professional workers need to be brought up to date on present knowledge and especially on future knowledge. New techniques of diagnosis, use of specific procedures, new knowledge of genetics, screening programs toward recognition of causative factors, etc., all need to be brought to the attention of physicians and allied medical workers through seminars, professional programs, and in-service training sessions. Every available technique should be utilized to disseminate information. Diagnostic and evaluation centers, research centers, and institutional care centers should maintain a free flow of information from one to the other and serve as information centers to the communities served. All such educational methods should be on a continuing basis.

There should be provided, through State and Federal levels, opportunities for key personnel to obtain courses on a postgraduate level. It is essential that these plans include provisions for scholarships and stipends to encourage individuals to take advantage of such courses without a loss of livelihood. At local levels, those in charge of funding agency staffs should be made aware of the value of staff personnel having opportunities to attend seminars or refresher courses that may be presented on a statewide or regional basis. There is urgent need for all disciplines in the health and allied fields to be refreshed in the behavioral and developmental patterns of children and in present knowledge related to mental retardation; however, once refreshed, each worker needs to be kept abreast of new knowledge and techniques.

RECOMMENDATIONS

It is recommended that existing health facilities, services and personnel be expanded and upgraded to meet community health needs. This, in turn, will mean a betterment of mental retardation services.

It is recommended that health education—vital to prevention of mental retardation—be improv-

ed at all levels. This should include education on maternal and child health services, especially prenatal, immunization, and safety programs.

It is recommended that there be developed a plan for the responsible growth of regional evaluation and diagnostic centers, to provide comprehensive services for the mentally retarded.

It is recommended that major research centers be located near medical schools and that programs be developed in cooperation with them.

It is recommended that health services for the retarded person and his family be furnished as close to the basic family unit as possible. Local communities must evaluate and organize health services thoroughly and effectively to achieve this goal.

It is recommended that current information, including new research knowledge, be made available on a continuing education basis to all medical practitioners and allied health workers. These individuals should continue to recognize their responsibility to use available knowledge, techniques, and services.

It is recommended that continuous action be taken at the State level for specific planning on the role of State institutions, their building programs, and their coordination with regional and area diagnostic centers.

3. MEDICAL ASPECTS OF MENTAL RETARDATION

The report and recommendations concernings the medical aspects of mental retardation are presented in five sections:

Section I—General Recommendations for Mental Retardation Planning. Principles important in the general approach to the problem of planning for mental retardation are presented.

Section II—Recommendations for the Prevention of Mental Retardation. Prevention is the only way to cope effectively with mental retardation. Present knowledge and means for making a great impact on the overall incidence of mental retardation through prevention are limited. Because of the catastrophic nature of mental retardation, however, feasible methods of prevention should be seriously considered in mental retardation planning.

Section III—Recommendations for Management of Mental Retardation. "Management" includes diagnosis of cause, evaluation of the capabilities of the retarded patient, counseling, and care and training.

Section IV—Recommendations for Research and Education in Mental Retardation. Research is needed in every aspect of mental retardation and is an important part of mental retardation planning. Recommendations for education concern education for workers in the field of mental retardation and, in addition, education of the public in prevention and management of mental retardation.

Section V—Priority Recommendations. Because of the broad scope of the medical aspects of mental retardation, and because of the limitation of funds, available facilities, and personnel, priority has been given to certain recommendations in this report.

The recommendations are *italicized* and are preceded by an explanation of the principles involved. Pertinent references are noted throughout the text and are given at the end of the section.

SECTION I—GENERAL RECOMMENDATIONS FOR MENTAL RETARDATION PLANNING

Planning and action to combat mental retardation require financing, facilities, expert consultation, and leadership at State and local levels. They require an assessment of available finances and facilities, and call for medical consultation and leadership, in association with other disciplines. Expert advice and consultation can be obtained from the following medical organizations, among others: Texas Medical Association, Texas Pediatric Society, Texas Academy of General Practice, Texas Psychiatric Association, and Texas Association of Obstetrics and Gynecology.

It is recommended that necessary medical consultation and leadership be provided to assist in planning, development and utilization of facilities at State and local levels.

It is recommended that an analysis of existing facilities and available funds for study, prevention, and total needs of the mentally retarded be made continuously at State and local levels and be used for planning to meet changing needs.

SECTION II
RECOMMENDATIONS FOR PREVENTION

Introduction. Mental retardation refers to subaverage general intellectual functioning which usually originates during the development period and is associated with impairment of adaptive behavior. Thus, an individual may meet the criteria of mental retardation at one time and not at another. A person's status may change as a result of changes in social standards or conditions or as a result of changes in efficiency of intellectual functioning, with the level of efficiency always being determined in relation to the behavioral standards and norms for the individual's chronological age group.

Two general types of mental retardation exists: (1) Those conditions which are the direct result of organic pathological processes, either anatomical or biochemical, which damage the brain (References 1, 2, 3, 4); and (2) those conditions which result from environmental circumstances and have no known physiologic or anatomic basis, but are either psychogenic or socio-cultural in origin. (References 3, 4, 5.)

It has been shown repeatedly and unequivocally that there is a remarkable correlation between the incidence of mental retardation and the adverse social, economic, and cultural status of families. It is of interest that conditions which are associated with many other health and social problems are, to a large extent, the same ones that are involved in the problem of mental retardation. In a depressed socio-economic environment the incidence of both types of mental retardation is at least five times greater than the incidence found under more satisfactory economic and social circumstances.

From a medical standpoint, the most significant and meaningful approach to reduction in the incidence of mental retardation is a concerted attack on the socio-economic conditions which produce most of the patients. (Reference 3.) In general terms, an immediate course of action is clear: General improvement in such services as health care, guidance, special education, vocational education, and the like directed at those economic groups especially prone to mental retardation. The same preventive measures which strike at the basic causes of mental retardation also may help to overcome other problems such as juvenile delinquency and general poor health.

A. Socio-economic Influences. There are three major areas in prevention of mental retardation associated with low socio-economic conditions:

1. *Improvement of general conditions and educational opportunities.* "A majority of the mildly retarded are children of the more disadvantaged classes of our society, characterized by low income, limited educational opportunity, unskilled occupation, and generally impoverished environment. These families must concentrate their meager energies on keeping body and soul together; they have neither means nor skills to provide their children with stimulating conversation, books, music, travel, or other intellectual and cultural advantages, those bestowed almost automatically on many children of the middle and upper income groups.

Children of these less fortunate families arrive at school age equipped with neither the experience nor the skills necessary for formal training. They are backward in language and in the ability for abstract thinking necessary for reading, writing, and counting. From these children come many of the dull borderline individuals who fill the special classes. Their failure to learn becomes complicated by frustration and anxiety; they may graduate to the streets and ultimately to the institution." (Reference 6.)

In order to prevent mental retardation due to "cultural deprivation," intellectual and cultural stimulation must be provided beginning in infancy and extending into adulthood. (References 7, 8, 9.) For the infant and preschool child from a low socio-economic background who is "high risk" for cultural deprivation, major attention should be focused on learning to understand the world of things and people, communicating with others, and developing attitudes and abilities conducive to school learning. (Reference 8.)

Opportunities for learning and motivation for older infants and preschool children should be established. This could be accomplished in special classes and education centers. For the "culturally deprived" child, adolescent and adult, special education classes should also be set up according to different intellectual levels, handicaps, and educational and job-training needs.

It is recommended that the medical profession, including the individual physician and the various medical societies, evaluate, support, and become involved in public and private efforts to improve the general conditions and educational opportunities of the low socio-economic groups of society.

2. *Child Health Supervision.* Poor health leads to sub-optimal intellectual performance. Health supervision from birth onward is necessary for maintenance of physical well-being and early detection of deviations of mental growth and development. Child health supervision includes: Routine periodic physical examinations, routine periodic dental evaluations, routine periodic mental developmental testings, routine laboratory examinations, and routine immunizations. In addition to providing good health, such procedures facilitate early detection of diseases and abnormalities of child-rearing practices which result in mental retardation.

In addition to low socio-economic conditions, the following conditions are associated with an increased risk for mental retardation in the involved infant and child: Parental consanguinity; pregnancy in the elderly mother; pregnancy in the adolescent mother; maternal history of repeated abortions and premature labor; out-of-wedlock pregnancy; prolonged maternal infertility; first trimester maternal infection with rubella; maternal syphilis; toxemia and bleeding during pregnancy; multiple births; premature births; perinatal hypoxia; neonatal hyperbilirubinemia; infantile dehydration; meningitis; encephalitis; head trauma; maternal deprivation; convulsions; congenital anomalies and cerebral palsy. (Reference 10.) This list will increase with expanding knowledge; involved infants and children should be followed closely for development of mental retardation.

An excellent method of providing health supervision for each newborn infant and child is continuous supervision by a private physician, pediatrician, or well-child clinic. (Reference 8.)

It is recommended that all infants and children have comprehensive health supervision, including preventive services and care of sick children. Expansion, improvement, and establishment of additional facilities for child health care should be made with emphasis on the economically deprived groups.

3. *Family Planning*. Cultural deprivation often is characterized by lack of family living and of knowledge concerning family planning. In addition, mothers who come from socially disadvantaged homes have more abortions, ectopic pregnancies, anemias, toxemias, and more babies with congenital malformations and mental retardation. (Reference 11.) Anatomy and physiology and family planning should be discussed beginning in junior high school and repeated in high school.

It is recommended that education for family life, including family planning, be provided in junior high school and again in high school.

It is recommended that local school, health and social agencies establish community education programs in family life planning for adolescents, adults, and young couples with consultation from the Texas State Department of Health and the Texas Education Agency.

It is recommended that health facilities under direction of qualified personnel provide information and materials for family planning among the economically and culturally deprived.

B. Genetic Influences. Certain genetic and familial diseases which result in mental retardation can be prevented through genetic counseling and family planning. Early detection of a few genetic diseases accompanied by appropriate treatment started in the newborn period may prevent or lessen brain damage. (Reference 1.) Examples of genetic diseases resulting in mental retardation are phenylketonuria, galactosemia, familial goitrous cretinism, homocystinuria, translocation Down's syndrome, the neuroectodermal dysplasias, Hurler's syndrome, etc.

Confirmation of diagnosis and management of these diseases frequently require expert consultation and counseling, elaborate diagnostic facilities, hospitalization, and expensive therapeutic measures; many cannot afford these services, and many do not have access to public facilities because of residential barriers such as city and county lines.

The recent legislation concerning phenylketonuria (P.K.U.) testing points up the necessity for uniform testing throughout the State. Major impediments to effective implementation have been: (1) The brief hospital stay of some normal newborn infants, particularly those delivered in the charity hospitals of our large cities; and (2) lack of effective follow-up of these newborn infants to assure early testing after discharge from the hospital.

It is recommended that groups containing a high percentage of mentally retarded persons, such as institutions for the retarded, special education classes, speech clinics, seizure clinics, neurology clinics, and cerebral palsy clinics and schools be appropriately screened in order to detect and provide appropriate management of genetic and familial diseases which result in mental retardation.

It is recommended that the Texas State Department of Health continue to provide and expand, where needed, the following laboratory tests for use by physicians, hospitals, clinics, etc. for diagnosing and managing genetic and related diseases: Chromosomal analyses, phenylalanine and other aminoacid blood tests, phenylalanine tolerance tests, exzymatic blood tests, qualitative and quantitative urinary bio-chemical (including aminoacid) analyses, and others.

It is recommended that existing public and private facilities be expanded and utilized for the diagnosis, care and treatment of genetic diseases which result in mental retardation.

It is recommended that legislation concerning P.K.U. testing continue to be reviewed by the Texas State Department of Health in conjunction with an obstetric-pediatric advisory committee.

C. Prenatal Influences.

Prenatal Care. Inadequate prenatal care, irregular care, care only during the last month of pregnancy, or no care at all, is associated with high infant mortality and morbidity. Kane's analysis of the data from the Foundation for Medical Research shows that American mothers generally have not been convinced of the need for prenatal care. (Reference 12.)

The number of women attending public sponsored prenatal clinics has decreased since 1950. (Reference 13.) In general, the percentage of women admitted to the hospital in labor with no prenatal care is on the increase. Obstetrical complications are nearly double in this group, when compared with women who had six or more months of prenatal care.

Little evidence exists to indicate that medical prenatal care by itself can prevent mental retardation. Nevertheless, first-class prenatal care is one factor associated with decreased morbidity and mortality, and this is reason to believe that improved prenatal care may also result in the lowering of the incidence of mental retardation. (Reference 14.)

The reasons usually given for not attending prenatal clinics by women are: (1) They sometimes had to wait six or eight hours for the five-minute check-up; (2) the clinics were poorly organized and staffed so that the mothers seldom got to know the doctors or even the nurses; and (3) there was no continuity of treatment and no plan was evident to the patients.

Many Texas cities, counties, hospitals, and foundations have no plan for the care of indigent patients. In others, the care is haphazard and based on "emergency admission." Large numbers of women in low-income families who are receiving poor or no prenatal care, have a high incidence of complications of pregnancy and deliver prematurely two or three times as frequently as the average for the nation as a whole. (Reference 11.) Such infants are especially vulnerable to brain damage, neurologic disability, and mental retardation. (Reference 15.)

The objective of maternity care is to find the more vulnerable patients early in pregnancy and to provide preventive health services and medical care for those who are likely to have conditions which are hazardous to themselves or their infants. The following are examples of conditions or circumstances which increase the hazards of childbearing for mother and for infant: Toxemias of pregnancy; hemorrhage; dystocia; anemia; malnutrition; hypertension; diabetes; infections; isoimmunization problems; multiple pregnancy; threatened premature labor; maternal history of premature births, miscarriages, etc.; pregnancy in women under 16 and over 40 years of age; out-of-wedlock pregnancy; and history of previous birth of infants with cerebral palsy, metabolic disorders.

It is recommended that expansion, improvement, and establishment of additional facilities for maternity care be made so that all women will have readily available continuing care under the supervision of a qualified physician with emphasis on the economically and socially deprived groups.

D. Perinatal Influences.

1. *Newborn care.* Follow-up studies indicate that 68 to 75 per cent of premature infants weighing less than 1,500 grams (3 pounds, 5 ounces) at birth have various physical and mental disorders such as cerebral palsy, mental retardation, speech and hearing disorders, visual disorders, and behavioral problems. (Reference 16.)

Prematures are more susceptible to infections, respiratory disorders, and the deleterious effects of certain drugs. Premature care requires special trained nursing personnel, neonatal pediatricians, and special equipment and facilities. (Reference 16.) Special facilities and personnel are also required for the care of all newly born infants. (References 17, 18.)

It is recommended that additional premature centers be established in suitable medical facilities in areas of need with the assistance of the Texas State Department of Health; that increased advisory and consultation services be provided by the Texas State Department of Health; that safe and specialized transportation of infants to these centers be provided, when needed, by the Texas State Department of Health.

It is recommended that premature and full-term nurseries be evaluated and licensed by the Texas State Department of Health in accordance with the standards recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

2. *Perinatal Study Committee.* (Reference 19.) There is no organized statewide perinatal

study committee in Texas. The major purpose of a perinatal study committee is to attempt to reduce fetal and neonatal deaths and to gain insight into the causes of non-lethal handicaps in surviving individuals. This requires complete investigation into the cause of each fetal and neonatal death. Since autopsy findings are essential to accurate definition of the cause of perinatal mortality, the number of autopsies among stillbirths and neonatal deaths must be increased in this State.

It is recommended that a statewide perinatal study committee be set up jointly by the Texas Medical Association and Texas State Department of Health to provide guides for perinatal studies, and to establish methods and procedures of obtaining and reporting epidemiological data.

E. Postnatal Influences.

1. *Accidents and Poisons.* (References 20, 21, 22.) Accidents sometimes can cause brain damage which results in mental retardation. Some examples are automobile involved accidents, falls, and athletic injuries. Poisons also can cause brain damage and mental retardation. This may be a result of chemical damage to the brain or interference with oxygen supply to the brain. Statewide programs in accident and poisoning prevention should be organized. In developing such programs, the following things should be considered:

a. Developing physician responsibility for prevention of accidents and poisoning by:
    (1) Teaching medical students and resident physicians courses and approaches to prevention.
    (2) Inculcating sense of responsibility for and status of this preventive effort.
    (3) Practicing physicians approached through professional societies and hospital staffs by programs, volunteer talks to lay groups, etc.

b. Encouraging Public Health Services to utilize their personnel in programs of prevention.

c. Stimulating hospitals, paramedical groups, and their auxiliaries to focus effort on this problem.

d. Stimulating youth groups and service organizations to program accident prevention talks and projects (e.g., use of National Safety Council packet).

e. Encouraging school systems to include accident and poisoning prevention in their health education program (e.g., traffic rules, bicycle safety).

f. Assisting industrial campaign efforts (e.g., safety rules for use of electricity).

g. Confronting the public constantly with educational information.
    (1) Newspaper reports of accidents, statistics, projects, safety awards, etc.
    (2) Reports from hospital emergency rooms.
    (3) Fire marshal's findings in home and industry inspection.
    (4) New dangers. Examples might be: (a) Suffocation with balloons or plastic bags; (b) small fireworks explosive resembling candy; (c) new industrial or agricultural poisons.
    (5) Stressing importance of local educational efforts. This might be done through: (a) Medical self-help courses; (b) YMCA swimming and water safety courses; (c) firearm safety courses; (d) courses in resuscitation.

h. Expansion, establishment, and improvement of driver education courses.

i. Studies and programs by Health Panels of Community Planning Councils, etc.

j. Encouragement and enhancement of athletic safety programs in schools.

k. Enhancement of seat belt programs.

It is recommended that all persons having responsibility for health care of the individual or for public health be challenged to utilize effectively the available knowledge in prevention of accidents; that the Texas State Department of Health be involved in the coordination and organization of a program in accident prevention.

It is recommended that the Texas State Department of Health continue to expand the statewide *poison control program in consultation and cooperation with established poison control centers. There should be better utilization of available knowledge for educational purposes and public awareness.*

2. *Infections.* Infections of the central nervous system (meningitis and encephalitis) cause neurologic damage and, frequently, mental retardation. (References 1, 2, 10, 23.) Infection of the gastro-intestinal tract (gastroenteritis or diarrheal disease), frequently causes dehydration which results in brain damage. (References 24, 25.)

About one-fifth of the deaths due to diarrheal disease in the United States occur in Texas. (References 26, 27.) Some of the neurologic sequelae which cause mental retardation can be prevented by early diagnosis and vigorous treatment of meningitis, encephalitis, and gastroenteritis. Certain medical centers in Texas treat large numbers of these cases.

It is only natural that better management is available in such a setting rather than in a hospital in which experience is limited to a very few cases. The expense of transportation to such centers and the cost of specialized hospital care is often a deterrent to optimum management. Financial assistance in this situation would result in improved care, particularly for residents of rural areas and small towns.

Certain viral encephalitides transmitted by mosquito bites can be prevented through mosquito control. In addition, certain infections which are commonly complicated by encephalitis and sometimes irreversible brain damage are preventable through active immunization. Two such common diseases are measles (References 28, 29) and whooping-cough (References 30, 31).

It is recommended that appropriate care facilities for children with infections which interfere with mental growth and developmental potential be utilized.

It is recommended that surveillance and control measures for the arbor-virus encephalitides, already in effect in Texas, be increased, including mosquito control measures, research efforts towards the elucidation of all possible reservoirs of infection, maintenance of a reporting system of all possible clinical cases, and maintenance of diagnostic facilities.

It is recommended that parents be encouraged to see that their children have routine immunizations, including measles and whooping-cough, except for cases where there are specific contraindictions.

SECTION III
RECOMMENDATIONS FOR MANAGEMENT

Introduction. Management means providing for the needs of the individual. In planning for the needs of the retarded individual, the family should also be considered and plans made for both the individual and his family. (See Figure 1.)

FIGURE 1—MAJOR AREAS OF NEEDS OF RETARDED PATIENT AND FAMILY

A. Regional Diagnostic and Evaluative Facility

C. Regional Institution for the Retarded

B.

Community

(1) Local Care Team

Patient and Family

(5) Foster Home

(2) Local Short Term Care Facility

(4) Special Work *Facility*

(3) Special Education and Vocational Training Facility

A retarded individual manifests the following symptoms: Impaired intelligence, delayed maturation, slowness in learning, and failure in social adjustment. Such abnormalities present many problems to the patient and his family producing much suffering, loss of work time, and expense.

Family problems associated with retardation in a member are as follows:

1. *Obtaining a diagnosis as to the cause of retardation.* This is important for treatment of the patient and family planning since the retardation in certain instances tends to be familial.

2. *Obtaining an evaluation of the patient's capabilities.* This is important in making decisions concerning education, training for work, and future role in society for the retarded person.

3. *Family counseling has many facets.* This is necessary to make it possible for the family to care for the child at home. The family also needs counseling in dealing with its emotional problems surrounding the retarded child. Examples of such emotions are guilt, fear, depression, despair, hostility, and non-acceptance of the diagnosis of retardation. The parents also need counseling on how to care for the retarded child. Everyday care activities of the normal individual such as feeding and dressing are major and complex problems in retardation.

4. *Special education and vocational training.* There is much that can be done for the patient in helping him to achieve his potential for happiness and work productivity.

5. *Abnormal behaviorial activities of the retarded individual.* Abnormal activities such as delinquency, truancy, hyperactivity, destructiveness, aggression, etc. cause severe management problems.

6. *Medical care.* Associated medical problems are congenital anomalies, accidents, cerebral palsy, blindness, deafness, epilepsy, psychosis, heart disease, and frequent infection.

7. *Family and home pathology.* Alcoholism, separation or divorce, breakdown of sibling relationship, and financial difficulties are examples.

In making recommendations for "Management," three facets must be considered: (1) A regional diagnostic and evaluation facility; (2) a regional institution for the retarded; and (3) the community in which the family lives. A retarded person and his family may have recurrent or continuing needs in all three areas during a lifetime. (Figure 1.)

A. Regional Diagnostic and Evaluation Facility. A regional diagnostic and evaluation facility (Figure 1) is characteristically a center to which the patient and his family can be referred for obtaining diagnostic studies, evaluation, counseling, and recommendations for management. (Reference 32.) After the patient and his family have been seen at the center, they return to the community to be followed by the private physician and/or local team (discussed below). Additional services, counseling and recommendations are provided on a continuing basis by the regional diagnostic and evaluation center as further problems arise. Such a center usually has available:

1. Comprehensive diagnostic and evaluative outpatient and hospital facilities.

2. Services of a team of interprofessional personnel. Pediatrics, psychiatry, neurology, psychology, social service, nutrition, occupational therapy, speech and hearing pathology, and education are examples.

A regional diagnostic and evaluation facility serves a whole section of the state, several counties, a county, or a city, depending upon distances involved and the population concentration. Such a facility also can be a part of another facility which deals with other handicaps, or it can limit itself strictly to mental retardation, depending upon community needs. The center can conveniently be located geographically in association with other facilities, such as cerebral palsy clinics, day care centers, community hospitals, regional institutions for the retarded, mental health clinics, medical schools and universities.

More regional diagnostic and evaluation centers are needed in Texas. At the moment only four such full-time facilities are available. A minimum of one per every 750,000 population is needed (or 13 centers for Texas' more than 10 million population) but it is doubtful that personnel for more than a few centers could be available in less than ten years.

> *It is recommended that more regional diagnostic and evaluation centers be established in areas where needed throughout Texas.*

B. The Community. The community has several needs in meeting long-term requirements of the patient and his family. It is important to meet these needs because the remedy for the increasing size of waiting list for beds in institutions for the retarded in Texas (References 33, 34) can be met by expanding means of managing retardates at the community level.

1. *Local care team* (*Figure* 1). A local care team in the community works with the regional diagnostic and evaluation center and institution for the retarded. (Reference 35.) It serves a city or a county, depending upon distances and the population concentration. A team is composed of local personnel: The private physician (or the public health doctor); the public health nurse; the public welfare worker, the home economist, the school teacher or nurse, and other interested community professionals. These personnel are part- or full-time depending upon their availability and the needs of the population being served.

The local team is useful in case finding, preliminary diagnosis and evaluation, liaison with regional diagnostic and evaluation facilities and regional institutions for the retarded, and assisting the family in caring for the patient at the community level. The team also performs a valuable service in organizing and helping establish local diagnostic, care, and training facilities. This does not have to be a formal arrangement, but an agreement among interested personnel to work together. State agencies would have to give their personnel at the local community level clearance to perform such duties. Such a team functions much better when a resource and liaison person—such as a social service case worker from the institution or regional diagnostic and evaluation center—visits and works with the team in the community setting. (Reference 35.)

In addition to the services of a regional diagnostic and evaluation facility, diagnostic and evaluation services and facilities are frequently needed for the private physician and/or local care team for use at the local community level. This has advantages when the services of a regional diagnostic and evaluation center is not available. An additional advantage is that the private physician and/or member of the local care team have usually known the family for years and frequently can do an excellent job of counseling and management.

This can be an arrangement whereby the private physician and/or team could obtain authorization to get complete physical examination, routine laboratory data, blood chemistry, electroencephalographic studies, pediatric and neurological consultants, and social service assistance, as well as psychological and speech and hearing testing at State expense for the patient who cannot afford it. This can best be done on a private basis by referring the patient to these services and facilities locally.

The public health nurse is an important member of the local care team. The availability of a public health nurse in the community is a *sine qua non* for the care of the indigent retarded patient and his family. A public health nurse is helpful in counseling the family in the care of the retardate in the home for all socio-economic levels. Many counties in Texas do not have the services of a public health nurse.

2. *Short-term care facilities* (Figure 1). One major problem is specialized short-term care outside the home for the retarded member. The care must be specialized in the sense of meeting the special care problems involved in retardation. Short-term care outside the home is needed for the following situations among others.

a. Daytime care when the mother has to work outside the home.

b. Continuous care for a week or longer when illness or some other catastrophic event temporarily disrupts family life.

There are many adult, mildly-retarded individuals who can work under supervision in the community in the daytime, but who do not have available supervision after working hours. Half-way houses are an excellent means of meeting such needs and should be established where needed.

Summer camps specialized for the retarded are an excellent means for providing vacation time and training for the retardate who lives in the community and should be established where feasible.

At present, many retarded individuals in Texas are institutionalized on a residential basis simply because there are no facilities at the community level where the patient could be left for short-term care. (Reference 34.) Day care centers, half-way houses, summer camps, etc., should be established where needed and feasible.

3. A special education and vocational training facility and a special work facility (Figure 1) are also community needs of the patient and family. Because of impaired intelligence and slowness in learning, the mentally retarded individual has these special needs. Many commun-

ities in Texas do not have such facilities. For similar reasons the mentally retarded individual may need a special work facility, such as a sheltered workshop.

Special education and vocational rehabilitation facilities should be provided in communities where needed. Special education should include vocational training and vocational rehabilitation facilities and services should be specialized to meet the needs of the retardate. The appropriate State agency should establish special work facilities for the mentally retarded in communities where needed. These services and facilities should be provided on a continuing basis as needed by the patient.

4. Foster homes for the mentally retarded. Much of the size of the waiting list for admissions to the regional institutions can be reduced by placement of retarded individuals in foster homes. There is no significant utilization of this avenue of placement in Texas.

One institution for the mentally retarded, the Pacific State Hospital in Pomona, California, has placed about 800 of its applicants in foster homes. This method has two advantages that institutions usually do not have: (1) More personalized attention for the patient; (2) a marked reduction in per capita cost. The appropriate State agencies should promote foster home care for the mentally retarded.

It is recommended that State funds be appropriated for use by the appropriate State agencies in the promotion and expansion of community care and training services and facilities for the mentally retarded. This should include the establishment, where needed, of local community care teams, short-term care centers, special education and training facilities, special work facilities, and foster homes.

C. Regional Institutions for the Retarded.

1. *Additional regional State institutions for the mentally retarded.* At present, the State institutions are overcrowded, and have long lists of patients waiting to be placed. (Reference 33, 34.) By opening more institutions in strategic areas, the census of the present State Schools could be reduced and allow for better care. Parents, by being closer to the institution, would feel more secure and would be able to participate more fully in programs. Additional regional State institutions for the mentally retarded should be provided.

2. *Service policies of institutions.* Frequently, short-term institutionalization is indicated rather than long-term care. It is also not unusual that emergency admission is indicated. A team approach including—as a minimum—the services of a physician, social service case worker, and psychologist should be utilized by the institution in determining the advisability of admission and discharge of the patient, and in the training and care of the retarded person within the institution.

Training, educational and care programs can only be successful when the retardate is healthy. For this reason appropriate medical care programs should be provided for the institutionalized individual. (Reference 36.)

There is often a need for short-term or early institutionalization of the very young infant. Frequently, retarded infants with gross anomalies (anencephaly, for example) or complex care problems (tube feeding, etc.) no longer require the intensive medical support available in the regular hospital; however, because of the emotional impact of such problems on the family, institutionalization is indicated. Institutional policies should be modified to meet such needs.

3. *Court commitment.* Court commitment to a regional State institution is now a policy. This is often unnecessary and frequently delays placement. It also frequently discourages the family. The current policy that all routine admissions to institutions for the retarded be court commitments should be modified so that retarded individuals may be institutionalized with or without court commitment according to the needs of the situation.

4. *Programs for delinquent retarded youths.* Special facilities are required for the management of delinquent retarded youths. Not only must the usual services of the typical State School be provided, but detention or security and special training facilities must be available. Special psychiatric services also are needed. Such facilities are inadequate in Texas.

Coordinated programs between the Texas Youth Council and the Texas Department of Mental Health and Mental Retardation should be instituted to provide appropriate programs, either in existing facilities or in new facilities, for the care and treatment of mentally defective delinquents with increased appropriate psychiatric services. Specialized programs for the care of retarded delinquent youths should be developed in one or more State Schools for the retarded.

It is recommended that additional State institutions for the mentally retarded be established, where needed, and that admission, discharge, care, and training services of the institutions in Texas be modified to more appropriately meet the needs of the retarded individual and his family.

D. Mental Health Facilities in Mental Retardation. A significant number of children are referred because of psychiatric, behavioral, or emotional disturbances. (Reference 37.) Failures of community care programs also frequently relate to parental inability to cooperate in adequate planning because of secondary emotional problems related to the retarded child.

Parent of retarded child. (Reference 38.) Mental retardation in an infant or child routinely gives rise to feelings of disappointment and anger in parents. Mechanisms for handling these perfectly natural but socially unacceptable feelings frequently lead to distortions in the lives of both parents and children. For example: (1) Premature placement outside the home or (2) clinging to, and over-protection of, the child kept at home, lead to dependency on the retarded child and sometimes neglect of some or all of the other children.

The retarded child. (Reference 37.) Constant frustration in learning to cope with his body and in trying to understand his environment as well as his brothers and sisters frequently leads the retarded child to employ unhealthy defense mechanisms to dull his continual feelings of disappointment. Denial of his deficit, assumption of a private fantasy world, blaming of other people for his failures while believing them unfriendly and unhelpful, and withdrawal from peer relationships especially in the teens are destructive defense mechanisms preventing the retardate from learning about himself, his friends, and his environment. All of these defense mechanisms limit still further his intellectual potential as well as his chances for happiness. In addition, many mildly retarded individuals do not learn because of severe mental illness or psychosis.

Psychiatric consultation from community mental health centers and child guidance clinics should be made available to physicians, departments of special education, and public health nursing units to increase the skills of these individuals who work with patient management and parent counseling. Private practitioners of psychiatry should be encouraged to make their services available to families of mentally retarded individuals. Mental health treatment services should be initiated within State residential facilities, either independently or in cooperation with State mental health facilities.

It is recommended that mental health consultation services be promoted and expanded to include services for the retarded and their families in both community and institutional locations.

SECTION IV—RECOMMENDATIONS FOR RESEARCH AND EDUCATION

A. General Recommendations. Research and education have several principles in common. These will be discussed under general recommendations.

1. *Multi-disciplinary approach to research and education.* Problems in mental retardation are often a combination of cultural, social, legal, and medical factors. The number of disciplines currently involved needs to be expanded to include such disciplines as law, anthropology, sociology, and epidemiology.

It is recommended that the Texas program on mental retardation support the recruitment of necessary personnel into the higher learning centers so that researchers and educators can make a multiple disciplinary approach to mental retardation in research and education.

2. *Training of personnel.* The problem of professional and semi-professional personnel shortage in the area of mental retardation is well known. It has been shown that supervised untrained or semi-trained workers can often perform tasks which will allow more effective utilization of professional time. The rapid expansion of programs in diagnosis, treatment and care of the mentally retarded dictates not only a better utilization of available personnel, but extension of programs for training.

It is recommended that State funds be made available for development of training centers for personnel in mental retardation at strategically located universities, at institutions and certain facilities for the retarded; and that research studies be conducted to determine what type of educational background is essential for each task in prevention, detection, and care.

3. *Legislation for research.* Federal, State and private funds are available and should be utilized by qualified personnel in Texas to keep abreast of research and development progress.

It is recommended that legislation in the State of Texas be reviewed so that it will utilize to the *fullest the acceptance of Federal, State and private funds to pursue research in mental retardation.*

B. Recommendations for Research in Mental Retardation Planning. It was not considered the responsibility of the Medical Aspects Task Force to recommend where research should be done or whose research should be funded. The type of research done is determined by the principal investigator in each project according to his ability, interest, and availability of facilities. Below are listed some areas of needed research in mental retardation which seem worthy of serious consideration for funding. For a general review of research in mental retardation, see Reference 39.

1. *Research in Causes: Medical and Environmental Factors*

a. *Research in biological and environmental causes.* At present, in only 10-15 per cent of the cases of mental retardation can a biological cause be identified. (Reference 4.) As already indicated, environmental factors also play a major role in mental retardation. It has been estimated that 65-75 per cent of all mental retardation is of the socio-economic type. The following are needed:

(1) Research into a better understanding of both bio-medical and experiential factors in the cause of mental retardation.

(2) Evaluation of effects of family planning in high-risk populations in the prevention of mental retardation.

(3) The development of central laboratories to conduct research into better methods of identification of genetic abnormalities.

(4) Research into the influence of day care centers for infants in poverty and deprived areas in preventing retardation.

b. *Research in sensory deprivation.* Many children who have inadequate mothering or intellectual stimulation in infancy and early childhood are considered to be retarded at some time in their life. Sensory inputs are extremely important in development. The question of how a child with a severe deficit compensates, remains unanswered.

Certainly there are many handicapped adults who are successful and well adjusted in spite of their hanidcaps. Avenues these individuals used to achieve these goals are diverse. They remain essentially unknown, and might provide valuable therapeutic techniques. Research should be done to determine the effect of sensory and other physical handicaps or intellectual development.

Specific areas in research should include investigation of successful groups of handicapped adults to uncover avenues they used in achieving their goals and to determine how those with specific sensory deprivation utilized the intact senses in learning situations. The influence of emotional adjustment on their intellectual development should also be evaluated.

2. *Research in methods of identification (diagnosis).* Early identification of mental retardation leads to early management and sometimes reversibility. The following are needed:

a. Research in the evaluation of new techniques for early detection of handicaps.

b. Research into the use of methods of establishing a "high-risk" registry.

c. Research in methods of *adequate* screening of newborns for phenylketonuria and other inborn errors of metabolism.

3. *Research in management and treatment programs.*

a. *Research in treatment of disease.* Patients with diseases such as galactosemia, phenylketonuria and cretinism often benefit from early detection and treatment. It is highly likely that other similar conditions exist. Those currently being treated are scattered over the State with various therapeutic regimen being used. Significant information concerning their progress is not available. The following are needed:

(1) Research in the coordination and development of treatment programs.

(2) Investigation of simpler methods of bio-chemical monitoring of these metabolic diseases.

b. *Research in management programs for the retarded.* Some studies which might be productive are:

   (1) Evaluation of the perceptual and thinking processes of the mentally retarded.

   (2) Research into the psychological consequences of training procedures.

   (3) Development of techniques of training of the mentally retarded.

   (4) Evaluation of effectiveness of electrical stimulation of the central nervous system in improving functioning and learning of the mentally retarded.

   (5) Evaluation of the effectiveness of day camps and teenage social clubs for the mentally retarded.

c. *Research in education programs for parents.* In the economically deprived groups, the children may have at a special facility an enriched program for a few hours per day, but then return to the same environment which produced the retardation. The goal should be to alter this environment by establishing parent training programs for homemaking skills, child rearing practices, and self-improved projects. Funds should be appropriated to study the effectiveness of these projects.

d. *Research in education programs for retarded persons.* Studies have shown that children with Down's syndrome make better adjustments at home than outside the home. Similar studies are needed on other types of retarded children to see which ones can be managed at home or in foster homes in a community and which are in need of institutionalization.

e. *Research in genetic counseling.* Various techniques are used in genetic counseling, and parents use the information in many ways. It has been shown that sound genetic counseling is needed for proper family planning. This information is also used by siblings in considering the likelihood of recurrence in their children. Research should be supported to study the effectiveness of counseling with parents and of the techniques used by the counselor.

4. *Research in the development of more effective preventive techniques.* Prevention of the causes and, therefore, prevention of mental deficiency should be one of the primary aims of any planned program for mental retardation. Funds should be appropriated by State and private agencies for:

   a. Research programs on prevention of biomedical and experiential causes of retardation.

   b. Broader socio-cultural research programs to uncover the optimum conditions of learning in the poverty stricken areas.

   c. Research into methods of increasing the effectiveness of prenatal care in preventing mental retardation.

5. *Research in area of epidemiological studies.* There is need for determining total census as well as geographic distribution of retardation for long-term planning of community health and educational needs. This requires that the incidence and location of persons with mental retardation in Texas be determined.

Prevalence studies should be conducted to determine the number and geographic location of the retarded in the State and the special needs of these retarded persons within certain ethnic groups.

6. *Research in techniques that can be used in service and education.*

   a. *Making knowledge available.* The gap between accumulated knowledge and practical application is rapidly increasing. There is a shortage of trained personnel available. Economy dictates the need for using information already at hand. Communication from one discipline to another requires more thoughtful and consistent attention. Adapting existing knowledge to unique local situations is mandatory.

   Many educational resources are available in certain communities and at various medical centers; however, similar resources are not readily available to physicians and other disciplines in small communities. It is recommended that funds be appropriated to the appropriate departments of the State to:

   (1) Study ways and means of putting existing knowledge into service.

(2) Support demonstration clinics for professional and non-professional personnel caring for the retarded in order to determine the best method of disseminating current information to communities.

(3) Compile an accurate index of existing resources that are available for continuing education.

b. *Management programs.* The trend is to keep the mentally retarded in the community; however, the effectiveness of existing community programs is not known. Knowledge is lacking on the exact effect of various community programs on families as well as the adjustment of the child in the community. Because of this lack of knowledge, there are many children in institutions who do not belong there as well as children in communities who should have been institutionalized long ago.

(1) Research studies should be conducted on the effects of various care programs for the retarded and on their adjustment in the community.

(2) Adjustment of parents and siblings of both institutionalized and non-institutionalized retarded children should be evaluated.

(3) Adjustment of educably retarded children compared to the average or superior students in a community school system should be evaluated further.

(4) The effect on families of day care for the retardate outside the home should be evaluated.

It is recommended that mental retardation planning and action in Texas include an expansion of research in etiology, prevention, care and education in the field of mental retardation.

C. Recommendations for Education in Mental Retardation Planning.

1. *Medical education.* Mental retardation is a medical responsibility even though the cause in many instances is socio-cultural. Knowledge of all factors involved need to be a part of the physician's skill in this area of medical practice. There is a shortage of physicians who have subspecialty training in mental retardation. While more specialists are needed to staff the institutions and diagnostic and evaluation centers, there is also a need to teach practitioners methods of prevention, early recognition, counseling of parents, and long-term management. Even though some introductory material may have been included in medical curricula, the rapid expansion of knowledge in this field demands both concentration in under-graduate as well as post-graduate training for the medical profession.

It is recommended that State funds be appropriated to medical schools for expansion and improvement of quality and quantity of medical education in mental retardation in medical school curricula.

It is recommended that medical schools and other institutions of higher learning be encouraged to expand their graduate and postgraduate training programs in order to increase the number of medical specialists needed in mental retardation and related fields; that these funds be used for scholarships and fellowships to:

(1) *Subsidize promising medical students and internes who are interested in working in the field of mental retardation.*

(2) *Increase the number of fellowships in residency programs for training in mental retardation and related fields (e.g., pediatrics, obstetrics, neurology, anesthesiology, psychiatry, genetics, surgical sub-specialties).*

(3) *Establish postgraduate fellowships in mental retardation for general practitioners, pediatricians, psychiatrists, neurologists, and geneticists.*

It is recommended that funds be appropriated to the appropriate State agencies for postgraduate courses devoted to mental retardation.

It is recommended that new knowledge in mental retardation be spread widely to all practicing physicians in Texas through meetings, clinics, official medical publications, and other accepted channels of informing the medical profession.

2. *Allied professional education.* Since many professions are needed in meeting the problems of the retarded, communication is needed between various allied workers in the field of mental retardation. The medical aspects of men-

tal retardation should be a part of the curriculum for nursing, occupational therapy, physio-therapy, special education, public health, social work, psychology, speech therapy, audiology, and others.

It is recommended that information on the medical aspects of mental retardation be included in the curricula of professional schools training persons who will later be giving service to or doing research in mental retardation; that a group of medical educators be made available to assist in such instruction.

It is recommended that funds be appropriated to the appropriate State agencies for supporting postgraduate courses on medical aspects of mental retardation for allied professionals.

It is recommended that funds be appropriated to establish fellowships for allied professionals in interdisciplinary training centers in mental retardation.

It is recommended that medical guidance and consultative services to hospitals, day care centers and others serving as caretakers of the mentally retarded be utilized for educational purposes.

3. *Public information and education.* Mental retardation affects everyone and its solution involves the cooperation of all; therefore, correct information about mental retardation should be available to the public. Awareness will help in institution of community programs and every avenue should be utilized for disseminating information.

Communications media, such as television, radio, lay magazines, and newspapers should be encouraged to include information about mental retardation in their programing. Films are available from the United States Public Health Service, several State health departments, university teaching centers, and private foundations on mental retardation.

Parent groups of the Texas Association for Retarded Children are already organized in many communities. They should be the focal point as leaders in making known the needs of the retarded. The public should be made aware of medical facts which relate to high-risk groups within various communities.

Public awareness is also extremely important in the prevention of mental retardation. A public awareness program on the prevention of mental retardation should include, among other things, the role of prenatal and natal care, immunization, child health supervision, accidents, poisons, infections and genetic influences; low socio-economic conditions, and the role of sensory and intellectual stimulation in infancy and early childhood.

It is recommended that funds be requested for the appropriate State departments for establishing statewide public information and education programs on mental retardation.

4. *University affiliated facilities and programs.* (Reference 40.) Residential centers need to be geographically near medical school campuses for mutually beneficial programs in teaching and research. The availability of a wide variety of subjects for clinical experience is a difficult problem for many institutions of higher learning. Residential institutions can provide an excellent resource for student and resident teaching programs. In addition, multi-disciplinary teams available in the institutions of higher learning could provide in-service training and consultation for management in institutions.

It is recommended that cooperative educational and service programs be continued between institutions for the retarded and university teaching centers; and that funds be requested for establishment of classroom and office facilities on institutional grounds for use of university personnel.

SECTION V
PRIORITY RECOMMENDATIONS

Due to the broad scope of mental retardation and the limitation of funds and available facilities and personnel, priority has been given to certain recommendations in this section. An increase in personnel in mental retardation and related fields is the most pressing need because any programs in prevention, management, education, and research will be severely handicapped by the lack of such personnel; therefore, priority should be given to recommendations that will accomplish this. Almost as pressing is the need to institute programs which will result in the prevention of mental retardation. Better programs for management of the mentally retarded also are needed. Priorities are as follows:

A. Personnel. Items (especially items concerning the education of personnel) in the Texas Plan that will result in an increase in the number and skill of professional and non-professional personnel in mental retardation or fields related to prevention, management, and education in mental retardation. Top priority should be given to recommendations that will result in an increase in the number and skill of medical and allied professional workers in the field of mental retardation.

B. Prevention of Mental Retardation. Items in the Texas Plan that will result in prevention of mental retardation. Top priority should be given to:

1. Improvement of general conditions and educational opportunities of the low socio-economic groups of society.
2. Improvement of maternity care.
3. Education in family life and planning.
4. Comprehensive newborn, infant, and child health supervision.
5. Immunization of infants and children.
6. Institutions of statewide accident and poison prevention programs.

C. Management in Mental Retardation

1. Local community care teams for management of the retarded.
2. More diagnostic and evaluation centers for mental retardation.
3. More regional institutions for the retarded and short-term facilities.

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4. EDUCATION AND TRAINING

The Texas Legislature in 1951 passed a law authorizing special education classes for educable mentally retarded children who are unable to profit from regular classroom instruction. In 1957, special classes for the trainable mentally retarded were included.

In 1965-66, there were 1,895 classes for the educable mentally retarded and 240 classes for the trainable mentally retarded in Texas public schools. Parochial and private schools reported in 1964 that they were conducting 402 classes for the educable mentally retarded and 107 classes for the trainable retarded.

Eighty-eight of Texas' 254 counties reported no education services for the mentally retarded. Many of these counties were sparsely populated and services for the identification of the mentally retarded were extremely inaccessible to them. However, a large percentage of the mentally retarded were receiving services in special classes, according to surveys conducted during the planning study.

Comprehensive and quality educational services to the mentally retarded in Texas are dependent upon adequate identification, qualified teaching personnel, and a curriculum based on realistic objectives. To plan and to institute educational programs for the presently known population of retarded persons would simply be a stop-gap measure. A primary goal is to operate and to maintain specifically designed programs at a consistently high level, for the benefit of all mentally handicapped.

All programs need the support of education specialists and professions from many other specialty areas outside the field of education. Another goal toward which those concerned with mental retardation can work is to marshal community resources for the educational benefit of the mentally handicapped and to make programs for the mentally retarded an integral part of the total educational offering within every community.

Adequate libraries and research projects are necessary to keep a forefront in the attack on educational problems of the retarded. Studies of current procedures, programs, and activities will be required to keep these offerings up to date. These studies need to be designed with realistic solutions as goals.

It is important that evaluative techniques be regularly applied to educational programs for the retarded in order to adjust and revise where services are of improper quality. It is equally important that correction of inadequacies be a direct result of the evaluations.

INTERAGENCY COMMITTEE

Several State agencies now provide services of some kind for the mentally retarded. It is difficult for one agency to know what other agencies have planned for a specific individual. Often there is a duplication of services by one or more agencies, and at other times one agency does not act because the service appears to be within the jurisdiction of another agency. Consequently, the mentally retarded person may never receive the services which he needs.

Furthermore, the retarded person is frequently unable to utilize available services without direction. Without communication and planning between agencies, there is little coordination of services. Thus, it is important that action on behalf of the mentally retarded be formalized and coordinated on a statewide basis.

TERMINOLOGY

Each agency and discipline which have responsibilities for services to the mentally retarded seemingly have coined their own terminology, often using some of the same words but with many different interpretations. The ability to communicate about needed services is dependent upon a language which can be understood and applied. Therefore, the adoption of standard definitions and terms relating to mental retardation is needed.

It is recommended that State agencies providing services to mentally retarded persons adopt the definitions and terminology of the American Association on Mental Deficiency, and that these definitions and terminology be applied uniformly by various State departments to determine eligibility of persons for available services.

MANDATED SERVICES

The present permissive law for educating mentally retarded persons in Texas public schools provides for school districts to establish classes when a sufficient number of eligible children live in that particular district. The law recognizes that transportation, special facilities, teaching equipment, and supplies are a part of special services, but no provision has been made to finance these extra items, over and above what is allocated for each regular classroom teacher unit.

Since some districts have fewer children than required for establishing a class, and since no provision for transportation is made to transfer children to a district providing special education, many mentally retarded children are at a disadvantage. Other children are at a disadvantage because some districts do not have enough classes to establish a sequential developmental curriculum. Teachers in a small program are penalized because there are too few to form a group for in-service education or plan conferences relative to improved curriculum and program development.

A need exists to assure comprehensive service to each retarded individual, regardless of where his home is located, and to enable school districts to provide educational services to each identified retarded individual.

It is recommended that the Legislature be requested to study the need for mandatory educational services for all eligible mentally retarded individuals in the state.

To insure comprehensive quality services to each individual, irrespective of his home district, it is believed that the following points should be considered in such a study:

1. Amend the special education unit allocation formula to ten pupils for each unit. Allocate funds to local districts on the number of pupils identified (one pupil equal 1/10 unit allocation).

2. Provide for a uniform statewide curriculum which includes evaluative workshop activities in public schools.

3. Provide for adequate facilities, equipment, and teaching supplies to implement the curriculum (financial support should be shared by the local district, State and Federal programs).

4. Finance adequate transportation to assure pupil attendance and participation in special programs.

5. Provide for trained and certified personnel for each unit.

6. Provide for vocational rehabilitation assistance to assure each mentally retarded individual adequate and sufficient services.

7. Provide for individual or multi-school district comprehensive educational units to serve the mentally retarded.

SPECIAL EDUCATION SERVICES

There is presently a lack of standardized, systematic, evaluative procedures for evaluation of mentally retarded persons and no provision is made for exchange of existing identifying data for mobile retarded persons. There are too few centers established where families with retarded children are able to go for diagnostic services, comprehensive counseling, and/or referral to available resources. To obtain these needed services, families may travel long distances and are often unaware of nearby facilities or of procedures required to obtain necessary services.

Library materials, curriculum coordination, and opportunities for training and retraining of teachers in service are not readily available. Administrative, consultative, and instructional services are not sufficient to provide quality educational programs.

Such Regional centers should provide, for the retarded person and his family: (1) A systematic screening and referral program;(2) complete evaluation and diagnostic services; (3) family counseling; (4) referral services for health, education, and welfare; and (5) exchange of information from one region to another for mobile students.

It is recommended that the Texas Education Agency establish area special education services for the mentally retarded to provide for: (1) *assurance of mandated educational services;* (2) *consultative service for school districts;* (3) *curriculum coordination;* (4) *materials centers and professional libraries;* (5) *in-service and retraining programs for teachers;* (6) *consultative services for the adult retardate programs.*

EXPANDED PROGRAMS

The public education system in Texas provides for two groups of the mentally retarded from 6 through 21 years of age. One group, classified as trainable, includes those with intelligence quotients of 35 to 50. Another group, classified as educable, includes those with intelligence quotients of 50 to 70. It is recognized that present educational provisions for the mentally retarded are not adequate to meet the needs of all retarded persons in Texas.

It is recommended that programs for the mentally retarded be expanded to include "borderline" mentally retarded pupils and additional services for the multiply-handicapped mentally retarded pupils.

It is recommended that the Legislature be requested to enact new legislation to permit the operation of educational programs for mentally retarded children with chronological ages under 6 years.

ANCILLARY PERSONNEL

Special education without ancillary services often is unproductive. Many educational programs for the mentally retarded have inadequate ancillary staff. Ancillary staff includes local program administration, supervision, and coordination, as well as sufficient specialists in curriculum, medicine, psychology, social work, public health, and recreation to assure quality of the programs.

It is recommended that the Legislature be requested to amend the Minimum Foundation School Program Law to provide adequate ancillary services that will assure a quality educational program for the mentally retarded.

COLLEGE STAFF AND CURRICULUM

In the optimum utilization of the program to combat mental retardation, college staffs face many problems related to pre-training and retraining of professional staff personnel, keeping abreast of changing data, and maintaining an up-to-date level of awareness. There is a need for better quality of educational pre-service training and retraining relating to new programs, curriculum designs, and testing of research results. Also needed is realistic design of research projects dealing with critical problems which arise in day-to-day contact with retarded persons. Colleges and universities need to make additional preparations and arrangements to train sufficient personnel to staff the proposed programs.

It is recommended that Texas colleges and universities be encouraged to develop their professional training programs in such quantity and quality as to assure a sufficient supply of trained personnel as needed to staff comprehensive programs for the mentally retarded.

It is recommended that the Division of Teacher Education and Certification of the Texas Education Agency have the responsibility and authority to administer and to insure the uniformity of modern professional training programs.

5. VOCATIONAL REHABILITATION AND EMPLOYMENT

Work is profoundly important to every person. It is no less important because a person might be mentally retarded. Mental retardation, and the enforced absence from the labor force that it sometimes imposes, only serves dramatically to make clear how crucial is work and a vocation. Vocational rehabilitation also becomes important for a person when his disability interferes with acquiring vocational skills and a job.

A wide array of vocational rehabilitation services for the retarded are available through private workshops, rehabilitation facilities, State agencies, and the Division of Vocational Rehabilitation in the Texas Education Agency. Despite progress in the rehabilitation of the retarded, it is evident that an extension of services should be provided to prepare more retarded persons in Texas for employment.

To establish a complete vocational rehabilitation program for the mentally retarded, the following services must be made available.

1. Social, psychological, medical, and vocational evaluations.

2. Counseling services to the mentally retarded, and counseling services to their parents to provide them with an adequate understanding of the employment potentials and limitations of their children.

3. School-work programs operated cooperatively by the public schools and the Divisions of Vocational Rehabilitation and Special Education of the Texas Education Agency.

4. Employment training facilities for those who require further vocational preparation after completion of the public school program.

5. Sheltered workshops for retarded workers capable of productive work in a supervised setting.

6. Supervised programs for on-the-job training of retarded workers.

7. Supervised living facilities while undergoing vocational rehabilitation services or working in sheltered employment.

8. Trained personnel to assist the mentally retarded in securing employment.

The recommendations presented below set forth proposals which would further enhance vocational rehabilitation services for the mentally retarded in Texas.

SHELTERED WORK AND LIVING FACILITIES

Sheltered employment and supervised living are essential elements in the rehabilitation of the mentally retarded. Of the 53 Mayor's Commission reports submitted, 29 cities recommended the establishing of sheltered workshops and 27 stated a need for supervised housing. Obviously, there has been a lag in the construction of such facilities.

The complexion of society is changing from rural to urban, and more mentally retarded persons are being trained and placed in gainful employment. Mentally retarded individuals formerly placed in State Schools are being habilitated to a life in the community. It becomes increasingly necessary to provide sheltered training and employment as well as supervised living for these individuals. Many retarded individuals will require life-time sheltered employment and supervised living while others will need only temporary services from such facilities.

It is recommended that sheltered workshops and half-way houses be made available in each metropolitan area having sufficient population to *support such facilities. (It is estimated that it will take a population of at least 70,000 people to support adequately a sheltered workshop or half-way house.)*

It is recommended that sheltered facilities, whether private or community supported, be financially secure; and that the responsibility for financing these facilities be borne by the local community, the State, and the Federal Government.

It is recommended that sheltered work opportunities be extended beyond traditional workshop settings. (Many community and service activities could be performed outside of a workshop through activities carried on under the professional guidance of facility personnel.)

It is recommended that the traditional philosophy of sheltered workshop operation be modified whereby workshops would become an important training agency for future placement of retarded persons in the community as well as providing sheltered employment for life.

UTILIZATION OF AVAILABLE FEDERAL FUNDS

Recent Federal legislation has made available additional Federal funds on a matching basis. Several phases of the Amendments to the Vocational Rehabilitation Act passed by the 89th Congress will affect services to the mentally retarded. These Amendments will provide the total rehabilitation program with additional case service funds through the utilization of available State General Revenue appropriations.

A portion of these additional funds will be channelled into the area of services to the mentally retarded. Also several provisions of the amendments will make grants available to sheltered facilities on a matching basis. These grants will be for the improvement of existing facilities and the construction of new facilities. Construction, renovating, staffing, and equipping sheltered facilities will be involved.

It is recommended (in order to assure the State of Texas of the full utilization of all Federal funds available for vocational rehabilitation) that matching State funds for sheltered facilities and other vocational rehabilitation projects for the mentally retarded include all community funds appropriated at the local level to assist in the development of community facilities.

It is recommended that the Texas Education Agency request continued support of the Legislature for increased general revenue funds to match Federal monies available for providing rehabilitation services to the mentally retarded.

EMPLOYMENT

It has been vividly demonstrated that the mentally retarded can be useful and productive employees if properly supervised. However, the majority of employers are not aware of the abilities of the retarded after they have been adequately trained. Consequently, employers tend to resist employing the mentally retarded. Since one of the goals of the rehabilitation program is gainful employment, it is important that every effort be made and all available services used in helping the retarded to find suitable employment.

It is recommended that the Texas Employment Commission continue and intensify the use of its trained personnel to assist the mentally retarded in securing employment as an integral part of the Commission's program of service to the handicapped.

It is recommended that consideration be given to the placement of mentally retarded persons in appropriate governmental employment.

It is recommended that business and industrial leaders be encouraged to employ the handicapped.

It is recommended that the Governor's assistance be requested to suggest to the mayors of Texas cities which have Mayors' Commissions for Mental Retardation Planning or local committees for employment of the handicapped that these local committees emphasize, as a part of their overall program, the employment of the mentally retarded.

It is recommended that union leaders and members of joint apprenticeship training committees be encouraged to accept mentally retarded persons into their training and apprenticeship programs.

STATE SCHOOLS FOR THE MENTALLY RETARDED

The six existing State Schools for the mentally retarded are presently operating within a philosophy conducive to vocational rehabilitation. The State Schools presently have personnel assigned to work with all adult students for the purposes of vocational evaluation and on-campus placement in various occupations within the institution. The students work under supervision and are continually evaluated for possible job placement in the community.

The Texas Department of Mental Health and Mental Retardation presently has working agreements with the Division of Vocational Rehabilitation, Texas Education Agency, for that Division to assign rehabilitation counselors in four of the six existing State Schools for the mentally retarded. Plans are being made for assigning vocational rehabilitation counselors to the other State Schools and any new facilities as soon as the need for vocational rehabilitation services is established in these institutions.

The vocational rehabilitation counselors assigned to the State Schools work with eligible mentally retarded students after their sixteenth birthday. In three of the State Schools, vocational rehabilitation counselors are directly responsible for on-campus placement and vocational evaluation for all students over 16 years of age.

In four of the State Schools, vocational rehabilitation counselors are responsible for all off-campus training and job placement of the students. Whenever possible, the students are placed on jobs in their home communities. This requires making arrangements for on-the-job training, counseling, supervision, sheltered living, and transportation during training.

It is recommended that more pre-vocational evaluation activities be established on State School campuses in order that a more realistic and practical vocational objective can be established for students with vocational potential.

It is recommended that a realistic and workable plan be worked out for transporting students to and from training and employment while they continue to live in the institution.

It is recommended that sheltered, off-campus living facilities in the form of half-way houses or foster homes be made available for State School clients during and after rehabilitation.

It is recommended that on-campus living and training programs such as the one established at Denton State School be established on State School campuses where such projects are feasible. These projects would be primarily for boys and girls from rural areas where training facilities sometimes are not available.

ELIGIBILITY

The existing State and private agencies engaged in vocational rehabilitation of the mentally retarded presently use various criteria for establishing eligibility for services. It must be recognized that some of the mentally retarded in need of vocational rehabilitation—with proper counseling, training, and job placement—will be able to function adequately in the competitive labor market.

However, a large number of the mentally retarded in need of vocational rehabilitation services will never be mature enough to function in the competitive labor market. Many of these individuals can be productive and partially self-supporting in terminal sheltered workshops if vocational rehabilitation services are available in their behalf.

It is recommended that all State and private agencies engaged in the vocational rehabilitation of the mentally retarded recognize the feasibility of offering vocational rehabilitation services to any mentally retarded individual with the ability to be productive; and that provisions be made to include both the mentally retarded capable of working in the competitive labor market and those in need of terminal sheltered workshop employment.

DIAGNOSTIC AND EVALUATION CENTERS

In order to offer a complete vocational rehabilitation program for the mentally retarded in Texas, it is necessary that early identification, early educational placement, and early pre-vocational evaluation be made available for them. Adequate services of this type are available at present in the large metropolitan areas; however, these facilities are almost nonexistent in the rural areas of the State. State and private agencies concerned with the vocational rehabilitation of the mentally retarded in rural areas have difficulty getting proper information needed to serve retarded clients.

PUBLIC SCHOOL WORK-STUDY PROGRAM

The Division of Vocational Rehabilitation and Special Education of the Texas Education Agency designed and introduced a program to bridge the gap between school and the world of work for educable mentally retarded persons. This is known as the Cooperative Program. Local school districts may establish this program in their school by signing a contract with the Division of Vocational Rehabilitation and Special Education of the Texas Education Agency.

A rehabilitation counselor is assigned to the local school district to work cooperatively with the special education teacher to evaluate the employment potential of the mentally retarded, arrange for on-the-job training, work experience training, job placement and follow-up. The Cooperative Program has proven to be a successful method of rehabilitating the educable mentally retarded; however, this program should be expanded to include all mentally retarded persons in need of rehabilitation services.

It is recommended that the development of cooperative programs (school work-study) be encouraged in school districts where they do not exist.

It is recommended that emphasis be placed on orientation programs for school administrators to inform them on implementation of these cooperative programs.

It is recommended that school officials be urged to work toward developing and utilizing the school facilities for developing the work experience phase of the public school program.

It is recommended that there be established adequate pre-vocational evaluation training programs on the junior high campus of cooperating schools.

It is recommended that programs similar to the cooperative program be established in schools which do not have special education classes or schools with small units which prevent the implementation of these programs. (This could be done on a county-wide or bi-district basis.)

SERVING THE MENTALLY RETARDED IN RURAL AREAS

One great need in Texas is to establish better vocational rehabilitation services for the mentally retarded in rural areas. Rehabilitation counselors presently are serving all 254 counties in Texas. However, providing effective and adequate rehabilitation services to the mentally retarded in the rural areas has been difficult.

Mentally retarded clients need close supervision in specialized facilities in order to be successfully rehabilitated. Counselors serving the rural areas have been unable to provide close supervision because of the large area they serve and the counselor-population ratio. Evaluation, training facilities, and employment opportunities are not readily available or accessible in the rural areas of the State.

It is recommended that encouragement be given to the developing and establishing of cooperative programs where they are feasible in rural areas.

It is recommended that the vocational rehabilitation counselor-population ratio be reduced so counselors serving the rural areas can devote adequate time necessary to effectively serve the mentally retarded.

It is recommended that bi-district or county-wide evaluation be established in training centers to serve the mentally retarded.

It is recommended that provision be made for day-to-day supervision of mentally retarded clients in on-the-job training stations in rural areas. (This possibly could be accomplished through volunteers from organizations and civic groups.)

It is recommended that workshops and half-way houses to serve clients from rural areas be expanded until such local programs can be established.

PERSONNEL

Recent legislation expanding the scope of vocational rehabilitation and the President's War on Poverty Program has created a shortage of qualified vocational rehabilitation personnel to fill existing and anticipated vacancies. The responsibilities of rehabilitation personnel working with the mentally retarded are so numerous and so widely diversified that only uniquely talented persons can perform all of them well. Personnel needs are critical.

It is recommended that ancillary positions be established which would not require full professional preparation, but which are necessary in the rehabilitation process, such as job centers for placement counselors.

It is recommended that professional personnel such as psychologists, psychometrists and social workers be provided to enhance the rehabilitation process.

6. SOCIAL WELFARE

SCOPE OF RETARDATION PROBLEM IN TEXAS NOT REALLY KNOWN

It is recommended that State agencies which serve students, clients, patients, etc., should identify those who are retarded, tabulate any data they have about these persons, and feed this data into a central data system so that the State's knowledge about the scope and cost of mental retardation services in Texas may be determined.

NEED FOR REGULATION OF SERVICES NOT PRESENTLY SUBJECT TO LICENSING

Much concern was expressed about the obvious need for State regulation of many services to children and handicapped adults which are not presently subject to regulation. Although the Texas Department of Public Welfare regulates child caring facilities and the Texas Education Agency regulates schools, there are many programs in the "gray area" in between which should be regulated. Specifically, these are "nursery schools," "kindergartens," and "day schools." These types of programs not only need to be regulated for the protection of the children but to assure parents who may be victimized by paying fees for erroneously labeled services of questionable value.

It is recommended that the Legislature be requested to extend State agency regulation to include "nursery schools," "kindergartens," and "day schools."

Another area which appears to need regulation is that of "half-way houses" and "sheltered workshops." With the push to integrate into community life retarded persons who are able to work and manage their own lives under limited supervision, there have been developed various facilities to serve them, such as vocational training programs, supervised dormitories, half-way houses, etc.

Despite the fact that these programs serve persons whose mental age may be childlike, the programs are not subject to State regulation because they serve "adults." These "adults" are sometimes easily led and may have limited ability to reason or do abstract thinking, a combination of circumstances which creates a fertile field for possible exploitation. Those who pioneered services to the older employable retarded persons have been altruistic individuals, but the retarded teenager or adult with money in his pocket may be easy prey for unscrupulous persons.

It is recommended that the Legislature be requested to extend State agency regulation to include "half-way houses" and "sheltered workshops."

FISCAL DEADLINE

In order for Texas to be eligible to receive Federal funds for Child Welfare services, maternal and child health services, and crippled children's services after July 1, 1975, these respective services must by that date be available in all counties in the State and also must demonstrate reasonable progress toward these goals each year in the interim. This appears to have great relevance to the development of services for retarded children as these divisions of these State agencies have many of the same goals outlined in this and other sections of the *Texas Plan to Combat Mental Retardation.*

TEXAS DEPARTMENT OF PUBLIC WELFARE (TDPW)

The Texas Department of Public Welfare (TDPW) has great capacity and potential to offer social services to the mentally retarded and their families.

Expansion of TDPW Casework Services

As the TDPW is the only State agency with services to people in every county of Texas consideration needs to be given to the feasibility of TDPW providing social services to the retarded in otherwise unserved counties. It appears to be in order also to consider the feasibility of providing services to all economic groups, not just services and money grants for the indigent.

It is recommended that TDPW, if requested, should serve the retarded and their families, without a means test, in counties lacking other social services, and should be enabled to accept fees from persons able to pay for services.

Whether or not the above courses are decided upon, constant attention to the quality of casework services is a necessity. Despite the frequently heard recommendation to lower caseloads, it is felt that lowering caseloads will not in itself improve the quality of casework.

The reduced caseload will be effective only if the other improvements are made. These include the appointment of qualified social workers and continuation of staff training and development by TDPW, and:

1. The availability and utilization of facilities for diagnosis, treatment, care, and training.
2. The exchange of knowledge and cooperation among agencies, institutions, and the communities they serve.
3. Increased professional and community awareness of mental retardation and the social problems it creates.

Protective Services For Older Persons

Retarded adults who lack suitable homes or responsible parents or whose parents are aged, infirm, or deceased, may have no one to turn to for protection, guidance, or training in ways to manage their own affairs. They may take pretty objects because they have never had any training regarding property rights. They may produce children without knowing the relationship between sex acts and conception and without the capacity to support, supervise, and guide their children. The retarded girl may be forced into a range of deviant behavior but may lack the inventiveness to find an escape from such exploitation. As retarded persons achieve gainful employment, they may be taken advantage of through excessive rent or exploitative contracts and may need help in using their earnings wisely.

It should be emphasized that although Child Welfare social services are available to persons up to their twenty-first birthday and to unmarried parents of any age, the court may not declare a person dependent and neglected after his sixteenth birthday.

It is recommended that TDPW be enabled, through legislation and increased staff, to provide protective social services for persons over age 15 who are in need of such protection. A clarifying study should be made of laws related to guardianships for retarded adults, either through the State Bar of Texas or as a follow-up of the Texas Mental Retardation Planning Study.

Research and Demonstration

In recognition of the desire of TDPW to improve its services to the needy, the 59th Texas Legislature included funds for research and demonstration in its appropriation for TDPW. Large caseloads and lack of community resources in the past have hampered seriously TDPW's attempts to deal with the special needs of its clients who are retarded. Now that caseloads have been reduced, especially with regard to services for children, and as community resources have and will continue to develop rapidly . . .

. . . *It is recommended that TDPW use some of its research funds to establish a demonstration project in intensive services to a selected group of retarded clients.*

Special Liaison Needed Among TDPW, Mental Retardation Programs, Personnel

The launching of the Texas Plan to Combat Mental Retardation will require special attention from TDPW.

It is recommended—to facilitate the effectiveness of TDPW in the area of mental retardation—that the Department have a staff consultant and/or advisory committee on mental retardation to guide its services to the retarded; and that *the TDPW provide special training for field staff regarding medical and social aspects of mental retardation relevant to the clientele of the agency.*

Licensing Program

Pressures sometimes have been exerted on State legislators to abolish the licensing program of the TDPW, which helps to protect children by requiring child caring and child placing agencies to meet minimum standards.

The licensing program of the TDPW, which helps to protect children by requiring child caring and child placing agencies to meet minimum standards, was endorsed by the Task Force on Welfare.

> *It is recommended that local governments be urged to continue full cooperation with the TDPW licensing staff through fire, sanitation, and health inspections and consultations, and when necessary through legal procedures affecting substandard programs which are dangerous to children.*

The Task Force on Welfare questioned the merits of a suggestion that TDPW develop separate licensing standards for facilities serving mentally retarded children because it felt this would justify the proliferation of special standards for facilities serving the crippled, the cerebral palsied, the blind, the deaf, the emotionally disturbed, and the multi-handicapped.

Instead, the Task Force agreed with the philosophy of TDPW of having licensing standards based on the needs of the "whole child" with additional requirements appropriate to meet the special needs of the handicapped children which a given facility serves.

The Task Force felt that all children, including those who are retarded, would benefit from upgraded minimum standards for licensing. Although the TDPW can refuse licenses or revoke licenses when facilities are dangerous to children, the objective of the licensing program is to help child care facilities to improve the quality of their services so that they can surpass minimum standards.

At present, services to children outside their own homes are in various stages of development and an immediate raising of standards would force many existing programs to raise their fees and/or possibly to cease operation. The only alternatives would be public subsidy of the facilities themselves, to enable them to acquire additional and better qualified staff, or a public subsidy of families to enable them to pay the higher fees required to support upgraded services.

Foster Care Funds Are Scarce

The therapeutic potential of foster care for retarded persons has been greatly overlooked. Because of the great demand for foster homes for homeless children, the financial burden for foster care of dependent and neglected children is already greater than many counties can bear. However, there are retarded children whose special needs could be met better in private residential care than in a State School. There are also retarded persons who do not require State School care who for various reasons cannot remain in their own homes. Further, there are persons on the waiting lists of State Schools who cannot remain in their own homes in the interim.

> *It is recommended that State and/or Federal child welfare funds be provided for the purchase of therapeutic care, foster care, and day care for exceptional children, and for professional homemaker services to improve their care in their own homes.*

SOCIAL SERVICES

Many communities have family and children's agencies, both public and private, which can be attracted to the challenge of making social services available to the retarded person and/or his family at the time of diagnosis if they need help in understanding the social implications of the diagnosis or in coping with the family problems related to the retardation.

Casework and Placement

Too often planning for care and training for retarded children is thought of as either home care or State School care without consideration of the many other types of care which might better meet the needs of the retarded person and his family.

Whatever seems the best plan for the handicapped member, the family should consider the various possibilities, choose one, and be helped to live comfortably with the decision. They also need to feel that no decision is for a lifetime and that it might be appropriate to have periodic reassessments of the retarded person's situation and their own to determine whether a new plan is indicated.

RESOURCES FOR CONTINUUM OF CARE

There needs to be a continuum of care resources. These should be selected so as to help the retarded individual lead a near normal life, to develop his level of self-help as well as other potentials including readiness for education or training and should also help the family achieve a well-rounded existence.

Families of the retarded need relief from their constant care and supervision even more than parents of normal children, yet there are very few resources for substitute care. If they have to work outside the home, the mothers of retarded children have exceptionally limited resources for substitute care.

It is recommended that a continuum of care resources be developed or expanded to meet the needs of the retarded and their families.

Some of these are described below, under the headings of child monitoring; homemaker service; day, night, and weekend care; short-term or emergency care; foster care, group care, half-way house, and institutions.

Child Monitoring (Baby Sitting)

An available supply of carefully screened child monitors in a community would enable some families to leave the mentally retarded member at home while they enjoyed activities outside the home occasionally. Some families could manage with this service, leaving the more intensive and expensive services for families needing more help. A local organization or agency should take the initiative in recruiting and training such persons to serve on a voluntary basis. The relevant experiences of United Cerebral Palsy Association could be utilized.

Homemaker Service

Homemaker service provides a substitute mother within a home when (1) the mother must be absent for a prolonged period such as for a serious illness, (2) or when she is physically or mentally unable to handle the full load alone, (3) or when she needs help in learning better home management, (4) or to learn techniques which will help her care for a member of the family who has special problems such as PKU, diabetes, crippling conditions, etc.

Homemakers are usually recruited, trained, placed, and supervised by welfare or health agencies. They may give special attention to the member of the family who needs extra attention, or may assist the mother with excessive burdens of responsibility. Consultant help in planning homemaker services is available from several national and state-level sources.

Day Care, Night Care
Or Weekend Care

In some instances it is in the best interests of all concerned for the retarded member to leave the home for care and training elsewhere a few hours each day or week although he continues to live in his own home. Outside care can be especially helpful for the retarded member whose family tends to underestimate his capacity for self-help. It can be helpful to the family, especially the mother, in relieving her of the stress of his constant supervision and physical care.

Day care on a regular basis is an essential for the retarded child of the mother who must work. The educational aspects of good care away from home can be very important for the child who comes from a deprived environment. Other families may find that care away from home for the retarded member is more desirable at night or on weekends, similar to night hospitals which have been successful as a means of treating mental patients.

Short-term or Emergency Care

Families with retarded members have the same unexpected crises other families have such as death, hospitalization, serious accidents, or unexpected urgent business trips, and like other families they also need vacations from time to time. But unlike other families, these families find it difficult to leave the children with the neighbors or to find a sitter who will remain in the home continuously for several days. Consequently, families with retarded members often suffer through a double crisis on these occasions. One family reported having to take its retarded member to a general hospital in order to leave town two days for a funeral.

Foster Family Care and Group Care

In some instances it is best that the retarded person live away from home either because of his own developmental needs or because he and his family need to be completely separated from each other for a period of time. Also, some retarded persons do not have suitable homes or parents who can care for them, but do not need to be in institutions. For these persons living with a substitute family may be best. Others who need less personalized relationships may respond best to group homes with others like themselves, supervised by house parents.

Half-way House

Many young adult and older retarded persons are just a step away from being able to lead completely independent existences and for them the half-way house provides opportunities to develop self-sufficiency in a somewhat sheltered environment.

Institutions

Some handicapped persons need intensive training, or constant and close supervision and care. Others have physical conditions requiring medical attention or special equipment. It would probably be unrealistic to assume that if a community had sufficient resources for care and training, there would be no need for institutions. However, it is important to remember that the modern concept of institutions is that although they provide lifetime care for some, other persons enter them only for a period of time but may later return to the community or the family.

7. RESIDENTIAL AND DAY CARE FOR THE RETARDED

INTRODUCTION

Attention in this section was devoted to planning: (1) For facilities and services to meet future population and program needs, and (2) for ways to enrich the programs of present facilities and to make maximum utilization of existing residential and day-care resources, both public and private.

Throughout the United States, the residential institution traditionally has been the keystone in the array of services developed for the mentally retarded. Too frequently the public has been assured that by providing residential facilities it has discharged its obligation to the retarded. The concept that the residential institution should be but one of a number of coordinated services has not yet been widely implemented.

The Task Force on Prevention, Clinical Services and Residential Care of the President's Panel on Mental Retardation succinctly summed up the challenge to those who presently are engaged in planning activities. The group called for a philosophy of care that would demand a definite reversal of former attitudes and practices. Retarded children have the same needs as other growing and developing children, but they and their families also need specialized services to meet the problems associated with their particular handicap.[1]

There should be a blending of services between the institution and resources in the community. There should be a systematic array of coordinated services designed to integrate the retardate into society. Wherever possible the basic aim of the total program should be geared to keeping the retarded child, especially infants and young children, with his family or else in foster home care. There is no substitute for family life.

Basic day-care considerations should include services which will strengthen the family group and assist the retarded individual in effectively utilizing the resources that are available to him. In other words, day-care services should enable the child to grow up as a member of his family and as a participant in community life.[2]

IMPLICATIONS: LOCAL, STATE, FEDERAL

In Texas, the State has attempted to meet the needs of the mentally retarded requiring residential care by building Special Schools. The Department of Mental Health and Mental Retardation administers six Special Schools which have a combined capacity of 11,500 beds. Three additional Schools for the Mentally Retarded are under construction or in the planning stage. These new schools will add approximately 2,900 beds to the present capacity over the next three years. However, it is anticipated that the waiting list, if the present trend persists, will continue to expand and will remain lengthy despite the opening of the new schools. Sustained expansion of residential facilities ultimately will commit Texas citizens to a tremendous future tax burden.

Private residential facilities serve a relatively small number of mentally retarded; nevertheless, they play an important role in the array of available institutional services. As contrasted with the large State-operated facilities, the private installations often have better staffing ratios and they have more flexible program policies. Usually, however, the fees for private facilities are beyond the financial capabilities of most families of the mentally retarded.

Day-care resources are limited in many Texas communities. They are almost nonexistent in rural areas. Undoubtedly many admissions to State residential facilities could be averted if more resources for day-care services could be provided in local areas. Community facilities, backed up by institutional resources, could make it possible for more mentally retarded to remain with their families and, at the same time, relieve the institutions of some of the pressures for admission.

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[1] President's Panel on Mental Retardation, *Report of the Task Force on Prevention, Clinical Services and Residential Care,* 1962, Pages 1 and 2.

[2] LaCrosse, Edward L., *Day-Care Centers for Mentally Retarded Children,* National Association for Retarded Children, Inc.

The new Federal program for cooperating with State and local communities in the construction of community centers offers great promise for more cooperative efforts among local, State, and Federal resources for more appropriately meeting the needs of the mentally retarded closer to their homes.

SUMMARY: THE TEXAS CHALLENGE

It has been obvious that past efforts to meet the varying needs of the mentally retarded in Texas have been discouragingly inadequate. This does not mean to decry the contributions of the many devoted individuals who have labored diligently to provide adequate services for the retarded. Conditions would be in a deplorable state if it were not for the dedicated energies of those who have been providing care both in public and private facilities. However, far-reaching changes are called for in the present mode of service delivery.

Perhaps uppermost is the need for a change in attitude toward residential facilities. The public will need to accept the philosophy that institutions should be used to meet the differential needs of the retarded individual rather than primarily as a resource for the community. Stated bluntly, the community should not use the institution to meet a need that should be met by the community. This is a serious disservice to the retarded child and his family, and it is an abuse of limited residential resources.

Also impressive is the need for more coordinated planning among the many agencies, public and private, in order to make maximum use of available resources. This need is particularly urgent among State agencies for statewide purposes and among the many local groups at the community level.

Whatever resources are developed in residential and day care for the mentally retarded, the resources in the institutions should blend with those in the community. This is essential in order to promote continuity of care and to assure the public that each retarded individual will have the opportunity to develop to his full potential.

It is recommended that there be established a network of regional centers for serving the mentally retarded and their families.

In addition to Legislative appropriations, maximum utilization of local and Federal funds should be sought to finance these centers. Such regional centers should strive to dovetail with existing resources in the region and should be flexible in composition so as to meet the unique characteristics of the region to be served. Chief goals of these centers should be the development of a continuum of care and the provision of continuity of services.

Applications for admission to Special Schools continue to be received by the Texas Department of Mental Health and Mental Retardation at a rate of 1,500 - 1,800 annually. It is becoming increasingly apparent that a sizeable portion of the applicants could and should be served locally or regionally if adequate resources are made available to the retardate and his family.

These new facilities should be flexibly designed so as not to duplicate existing resources in the area to be served and should complement the region so as to provide the following basic services: (1) Diagnosis and evaluation; (2) counseling for parents; (3) day care; (4) short-term residential care; (5) sheltered employment opportunities and work evaluation; (6) information, education, and referral; (7) consultation to regional agencies and institutions of higher learning; (8) homemaker service; (9) foster home placement coordination; (10) halfway house operation and supervision; and (11) research and training, as appropriate.

In remote areas, mobile service teams should be established and operate out of existing regional centers and/or residential institutions.

Program planners should be cautioned that categorical and *a priori* decisions that all centers should be either separate or combined may lead to ineffective programs. The decision as to whether a given regional center should combine services for the mentally retarded with those for the mentally ill should be based on several factors, including the characteristics of the region to be served, existing services, availability of manpower, the need, local desire and interest, etc.

It is recommended that empirically evaluated demonstrations using both separate and joint centers in urban and non-urban areas be carried out and that the Legislature be requested to appropriate funds to the Texas Department of Mental Health and Mental Retardation for establishing operational models.

Since the process of diagnosis and evaluation usually involves the same skilled professional manpower in providing such services for both the mentally retarded and mentally ill, and since manpower is in short supply, there may be advantages to combining mental retardation and mental health services in a single regional center.

However, it is recognized that professional specialization leading to competency in working with mentally ill adults may not automatically qualify the professional to work effectively with retarded children and youth. Further, Texas' experience in providing services of the type mentioned in either joint or separate centers is too limited to allow broad generalizations. Empirical investigations of the effectiveness of services in both joint and separate centers should be conducted.

Where joint centers are authorized and operated by the Texas Department of Mental Health and Mental Retardation, any advisory boards which may be organized or appointed should reflect an equal weighting of members having interest in each of the areas of mental retardation and mental illness.

The mechanism of Texas Department of Mental Health and Mental Retardation grants-in-aid to local communities is viewed as a basic and essential resource for assisting communities and regions to increasingly assume a greater share of the responsibility for the development and coordination of mental retardation programs.

> *It is recommended that the Legislature be requested to appropriate to the Texas Department of Mental Health and Mental Retardation significantly increased amounts of money to facilitate the grants-in-aid program; and that priority in awarding such grants be given to projects which have potential for demonstrating new and meaningful approaches to developing mental retardation case finding and diagnosis, care and treatment programs, and restoration or rehabilitation.*

House Bill 12 (59th Texas Legislature) establishes the grants-in-aid mechanism to qualifying centers. The goal of combined Federal, State, and local fiscal assistance to communities to aid in the development of mental retardation programs and services is deemed essential if maximum resource utilization is to be realized.

The present Legislative appropriation to the Texas Department of Mental Health and Mental Retardation to implement the grants-in-aid program is viewed as token in nature. Increases in these funds should be forthcoming to permit a broad-scale plan of assistance to those local communities which demonstrate interest and potential for assuming a larger share of the responsibility for establishing effective mental retardation services.

Day-care service is a new and emerging pattern of programming for the retarded in Texas which offers considerable potential for serving the retarded person within the context of his home and family.

> *It is recommended that Special Schools, regional centers, and other service facilities as may be operated by the Texas Department of Mental Health and Mental Retardation offer day-care training, as appropriate, to the retarded from a very early age; that the day-care function be an integral part of the continuum of services which includes diagnosis, parent counseling, and referral services; and that the Texas Department of Mental Heath and Mental Retardation in establishing and operating day-care programs, should not duplicate existing services in the community.*

It is readily recognized that many families could care for their retarded family member in the home with appropriate supportive services. Day-care, in which the retarded individual spends all or a portion of the day in special training-care-supervision setting, affords him opportunities for growth development and association with other persons of his age and ability level. At the same time, the parents are freed from supervision of the retarded child to pursue other duties relating to housekeeping, work, etc.

Physical and mental strain are produced by the constant supervision required by many retarded individuals. The day-care approach to assist in the alleviation of this problem is endorsed. Flexible movement of retarded individuals from day care to other existing programs (e.g., education, habilitation, sheltered workshop, etc.) should be carried out as the needs and circumstance warrant.

> *It is recommended that the Texas Department of Mental Health and Mental Retardation be authorized to establish new residential facilities as needed; that the location of any new facilities be determined after a careful study of the need factors and resources in the geographical area to be served and that they adhere to the basic concept of proximity of care.*

Specific future sites for institutions are not recommended, but priority of study should be given to a study of the residential need factors involving the El Paso area, the Rio Grande Valley area, and the northeast Texas area.

The importance of H.B. 41, which now permits the TDMH/MR to establish the sites of new Special Schools, is reaffirmed. In addition, the nature of the mental retardation problem in the regions mentioned above suggests the need for expanded residential services in these areas.

The sizes of residential facilities of the future should be planned so as to accommodate effectively their resident populations.

> *It is recommended that increased attention be given to planning for smaller living units (i.e., dormitories or wards) to allow more homogenous groupings and permit increased amounts of individual attention in care and training programs.*

Study should be given to the merits of special purpose institutions (e.g., where all residents are bedfast, etc.) and/or to the creation of special purpose units or sections (e.g., to serve the physically handicapped retardate, etc.) within institutions.

A 2,000-bed residential facility in or adjacent to a large metropolitan area may be capable of providing more effective services than a 500-bed facility situated in an area where professional manpower and ancillary services cannot be obtained. However, the general principle that residential facilities should also serve as regional centers and provide a broad array of services to retarded residents in proximity to their homes and families suggests that two 1,000-bed institutions will be more effective in fulfilling this over-all responsibility than will a single 2,000-bed facility. Cost comparisons between institutions of different sizes must include consideration of the magnitude and quality of out-patient services as well as the traditional residential (in-patient) service load.

> *It is recommended that existing residential facilities, to the extent practical and feasible, along with all future new institutions, be converted or constructed to serve the regional center function; that in the case of existing institutions, Legislative support in the way of additional staff and facilities be authorized to facilitate conversion to the regional center approach in which diagnostic and evaluation services, along with a broad array of out-patient and in-patient services, could be provided.*

As required, additional professional staff and facilities should be made available to existing Special Schools to enable them to provide a full range of services to both in- and out-patients. Staff members who can devote a portion of their time to consultation with correlated service agencies in the field should be made available as an integral part of the regional center approach.

> *It is recommended that the Texas Department of Mental Health and Mental Retardation develop and establish realistic and practical guidelines to be used by the State Special Schools, and other State and local residential facilities for the mentally retarded, in providing adequate and appropriate personnel staffing patterns and operational standards.*

> *It is recommended that the Legislature be requested, on sound justification, to appropriate sufficient funds to enable all State Schools: (1) To meet minimum staffing and operations standards to service the in-patient populations and, where appropriate, to assume the regional center role; and (2) to raise the salary levels of child care and related personnel in order to recruit and retain high quality workers.*

Assumption of the responsibility for caring for large numbers of retarded Texas citizens calls for an adequate professional staff to conduct ongoing evaluations of resident progress, implement leadership to nonprofessionals in training programs of various sorts, and communicate effectively and regularly to the families of these individuals.

Appropriate State agencies should continue to provide programs to serve retarded persons who are blind, deaf, physically handicapped, or who have other such disabilities in addition to their intellectual deficit.

Regional centers for certain disability groupings and/or the operation of special service units within institutions should be initiated. Where indicated, State agencies should cooperate in joint planning, implementation, supervision, and evaluation of these endeavors.

Program planning and implementation for the multiply handicapped retarded child calls for specially trained staff and unique facilities and equipment. Increased efforts should be made by the State agencies to develop new programs serving these individuals, and to cooperate on basic program responsibilities in the non-retardation aspect of the multiple problems represented.

In the case of retarded residents of Special Schools, consideration should be given to grouping like multiple problems (e.g., blind retarded, deaf retarded, cerebral palsied, etc.) from the Special School network at a single institution. Frequently, it is only in this way that enough representatives of a given disability group can be amassed to justify the specialized personnel and equipment that may be necessary for successful program implementation.

It is recommended that—in providing for a continuum of services between the community and residential resource—provisions be made for transitional types of services such as halfway houses and group-living arrangements, off the campus of an institution.

Arrangements should be made for transportation for day-care and halfway house participants.

It is recommended that the Legislature be requested to authorize one or more demonstration units of this nature with the appropriate State agency exercising quality control of these programs through licensing or some similar plan.

As with the Community Mental Retardation Projects authorized by the 59th Texas Legislature, there is a need for demonstrating the potentials of the halfway house and group living arrangement for retarded persons as: (1) A deterrent to admissions to Special Schools; (2) A means of assisting Special School residents with rehabilitation potential to make the transition into either full or partial community living; and (3) A model to give both the TDMH/MR and communities knowledge about the effectiveness and potentials of such service units. In establishing and operating such a demonstration, close cooperation between the various State agencies having correlated responsibilities should be maintained.

It is recommended that the Legislature be requested to appropriate sufficient funds to each Special School and to each regional center to allow each of these facilities to establish and operate foster home programs for the mentally retarded.

Sufficient staff and supportive services should be made available to implement this recommendation. Expenses to be covered include room and board, medical expenses, follow up, and other items necessary to the program's success. Close cooperation should be maintained between the TDMH/MR and the Department of Welfare in implementing and administering an overall foster home program for the retarded.

The Mentally Retarded Persons' Act establishes the authority of the TDMH/MR to make foster home placements. Funds have not yet been available, however, to implement a foster home operation. It is recognized that a rather sizeable proportion of Special School applicants and residents might be alternately served by such a service. Other states which have initiated programs of this nature have reported highly successful results. These programs should be visited and studied in order to derive maximum benefits from their experiences.

It is recommended that the TDMH/MR strengthen and broaden, in its various facilities, education and rehabilitation services to the mentally retarded.

A full range of services should be developed, including prevocational and vocational evaluation and training, sheltered workshops, residential supervised employment and training, off-campus employment, halfway house placement and employment, and community group living and working facilities and programs. Close cooperation should be maintained with the Texas Education Agency in the planning, operation, and evaluation of these various endeavors.

A concept of rehabilitation should be adopted which would promote the basic theme of permitting each retarded person to develop to, and perform at, his full potential. Using this approach, "being rehabilitated or habilitated" would not necessarily involve the retarded person's return to the community. The concept to be emphasized places the retardate's functional level in competition with his own potential—not his functional level against the functional level of others in society.

It is recommended that the Legislature be requested to appropriate funds to implement previously passed legislation permitting remunerative work assignments for the mentally retarded within the institution; that this provision also apply to regional centers operated by the TDMH/MR; and that funds be made available to the TDMH/MR to increase the numbers of professionals supervising work and training assignments within the institution or center, establish workshops, obtain contracts, and, in general, coordinate these and related activities.

Proper safeguards should be included in these programs to insure that a continuing focus on training and/or therapeutic activities is maintained. Special Schools are currently authorized to pay working residents; however, funds have not been available for this purpose.

Work and compensation for work are cornerstones of modern society. Work can be a motivating force in shaping behavior and preparing the mentally retarded by ultimate return to society. A carefully planned system of work should be an integral part of the programs of institutions, regional centers, and other service facilities which, may be developed by the Department.

It is recommended that the TDMH/MR inventory its record-keeping procedures, especially those dealing with patient movement and services, and implement new and/or strengthened record-keeping procedures as required.

Much of the effectiveness of the total program, existing and planned, will be evaluated through base line and other records relating to populations served, types of services rendered, etc. Both research and service programs will require accurate and efficient data input and retrieval systems. Cooperative undertakings with other State agencies, including institutions of higher learning, should be carried out to establish such a record system. Close contact and participation with national reporting systems should be encouraged.

It is recommended that the Department expend new efforts to identify and assist in the development of institutional staff members who demonstrate promise as future administrators of Special Schools, regional centers, and other service units which may be operated by that agency. It is specifically recommended that each Special School be authorized to create the position of assistant superintendent to: (1) *Assist the superintendent with the administration and operation of an increasingly complex array of residential and out-patient services and programs; and* (2) *give promising and capable individuals the opportunity to gain valuable and broad training experience in the supervision and administration of these endeavors.*

The future of mental retardation programs in Texas resides in leadership. The TDMH/MR should make every effort to identify and reward leadership potential in its mental retardation programs. The example set in providing Assistant Superintendents for certain mental hospitals is a commendable procedure and one which would be followed by the Special Schools if a continuing flow of qualified administrators is to be maintained.

It is recommended that the Legislature be requested to allocate increased funds to the Department to be used to upgrade the training of existing departmental personnel in all levels and professional fields and to attract new professional workers into the system.

Review of the policies on the use of these funds is recommended, the goal being to permit maximum flexibility in assisting promising and qualifying personnel to receive advanced training to better equip them to contribute to total program effectiveness. The shortage of professional personnel is acute. Steps should be taken to upgrade the skills of existing personnel in all fields and to insure a continuing flow of qualified personnel to staff new programs.

It is recommended that the TDMH/MR continue and strengthen its practice of utilizing volunteers to enhance its service programs.

The use of volunteers enables institutions to provide personal attention to residents, both material and service in nature, not otherwise possible. In addition, volunteers represent an important vehicle for transmission of information about mental retardation and mental retardation programs operated by the Department to the public at large. Study should be given to new approaches in recruiting volunteers and to making their assignments more meaningful and productive in scope.

It is recommended that the TDMH/MR strive to maintain flexible admission and service policies at its various facilities; and that there be a periodic review of all such policies.

The exclusive use of court commitments to admit retarded individuals to the jurisdiction of the Board of Mental Health and Mental Retardation is undesirable. It is understood that the TDMH/MR is currently in the process of abolishing court commitment as an absolute prerequisite for admission to a State School. Future eligibility and admission criteria should stress the continuity and immediacy of care concepts.

Texas ranks high among the various states in the total number of military personnel making up its population.

It is recommended that the TDMH/MR review its admission policies and eligibility criteria regarding these families; and that it explore with Federal officials cooperative means to serve these often-transient families.

Dependents of military personnel who qualify as Texas citizens are eligible for Special School placement. Non-resident families stationed in Texas, however, do not qualify for TDMH/MR residential services. Recognizing that the basic concepts of proximity of care and residence with the family are significant in conducting programs for the retarded, some means should be worked out to provide comprehensive services to the retarded dependents of military families stationed in Texas. This includes residential placement, if needed.

Concurrently evident is the potential influx of large numbers of dependents of non-residents (non-taxpayers) whose families are then transferred elsewhere, only to leave the retarded dependent as a burden to the Texas taxpayer. This situation is to be avoided. One possible solution is the encouragement of the Federal Government to construct and maintain one or more residential institutions within the State for the benefit and use of its military personnel.

It is recommended that the TDMH/MR's system of fee assessment to families of retarded children being served in institutions, regional centers, and other facilities be continuously reviewed in order that fair and equitable charges be assessed for services rendered; that the TDMH/MR establish a formal appellate structure through which parents may make appeal if they feel assessed charges are inappropriate; and that the guidelines for fee payments established by the National Association for Retarded Children be studied and implemented where possible.

The dependent retarded child may represent a lifetime economic burden to the family. Fee assessments should be established in a flexible manner and should take into account multiple factors in the overall family situation, including income, commitments to other children in college, etc. Consideration should be given to the desirability of limiting or significantly reducing payments after a dependent retarded child reaches his majority, or after a designated period during which the family has paid (e.g., after "X" years).

It is recommended that the TDMH/MR embark on an active plan of designing and carrying out informational and educational workshops for key professional groups in the various communities of the State, to enhance the knowledge and skills of these personnel to facilitate better services to the non-institutionalized retarded and his family.

Cooperation with other relevant State agencies in the funding, planning, and implementation of these conferences should be pursued. An example of the type of endeavor envisioned here would be a cooperative undertaking between the TDMH/MR and the Texas State Department of Health to plan and implement a workshop for community dentists to better acquaint them with the dental characteristics, needs, and problems of the mentally retarded.

The trend calling for increased community responsibility in serving the retarded in the home and community must be accompanied by well-planned and meaningful efforts to strengthen local resources to assume this responsibility. Strengthening the knowledge, skills, and awareness of those professionals now living and working in communities, relative to mental retardation, should be a top priority in preparing the community for its new role in the treatment continuum.

It is recommended that the TDMH/MR assume a more active role in working with communities to establish effective recreational programs for the mentally retarded.

Such programs would serve both non-institutionalized retardates as well as institutionalized retarded persons on leave from the institution. These programs should focus on the development of activities which span week ends, evenings, and the summer months. Consultation from departmental staff should be made available to community recreation programs.

While a few communities have developed outstanding special recreational programs for exceptional persons, most cities and regions offer no special recreation resources of this nature. Recreation is viewed as both an adjunct to the social and physical development of the retarded and as a valuable resource to the family in making provision for a well-balanced plan of care for the retarded individual living at home.

It is recommended that Special Schools, regional centers, and other service facilities as may be developed and operated by the TDMH/MR make provision in their programs for parent education (for the parents of both in-patients and out-patients) designed to better equip them to care for their retarded children at home and in the community.

As new information is generated by the TDMH/MR and its various service facilities, enhanced efforts should be made to impart this knowledge to parents in an attempt to upgrade their skills and competencies in dealing with their retarded children.

It is recommended that the TDMH/MR and the Texas Youth Council jointly formulate appropriate plans to study and meet the problem of the delinquent retarded child in Texas. As an interim and supportive measure, it is recommended that each State School be authorized to establish a small, special unit for delinquent defectives.

The advent of successful special education and rehabilitation programs at the community level can be expected to siphon off the more mildly retarded retardates. However, those retarded individuals whose social behavior threatens program integrity at the community level are being referred in greater numbers to the programs operated by the TDMH/MR and the Texas Youth Council.

While these two agencies are responsible for planning programs for the retarded and the delinquent, respectively, neither is adequately serving the defective delinquent at this time. The *a priori* assumption that the mental retardation component is necessarily the underlying causative mechanism in the defective delinquent's antisocial behavior may be fallacious and may lead to a failure to search out other relevant variables associated with the problem.

8. MANPOWER—THE KEY TO PROVIDING NEEDED SERVICES

OVERVIEW OF NEEDS AND RECOMMENDATIONS

The manpower development section of the Texas Mental Retardation Planning Study was centered upon three basic tasks:

1. To determine how many people in Texas now are working in the field of mental retardation services (prevention, treatment, rehabilitation, etc.).

2. To ascertain how much service, both current and anticipated, must be provided from the mental retardation manpower pool.

3. To determine how to strengthen and increase personnel in order to meet the needs of the mentally retarded and to make sure that comprehensive preventive services are provided for high-risk groups.

Authorities in the health disciplines have pointed out that there is a shortage of professional personnel—a manpower pool problem—on most levels. Data which support this point of view were compiled during the Texas planning study.

For example, the director for personnel management of the Texas Department of Mental Health and Mental Retardation made an estimate of manpower needs in the State Schools for the retarded. He found (based on established standards of the American Association of Mental Deficiency) that the most critical shortages existed in the following areas:

1. Medical doctors.
2. Professional nurses.
3. Professionally qualified social workers.
4. Psychologists.
5. Additional staff members adequate to meet supporting needs.

A faculty member of the School of Social Work, The University of Texas, has estimated from his own study of social welfare needs and from other sources, that more than 900 additional professional social workers will be needed in Texas by 1975. He reported that the Texas Department of Public Welfare alone will require a minimum of 400 additional professional social workers.

Other indications of future manpower problems and challenges:

1. The Texas State Department of Health, Division of Mental Health (now the Community Services Section of the Texas Department of Mental Health and Mental Retardation) estimated in 1964 that an additional 161 professional social workers will be needed to staff community clinics, centers and general hospitals by 1974.

2. The director of special services for the Pasadena (Texas) Independent School District found that approximately 3,700 more special education teachers are needed now in classroom units (for mentally retarded children in Texas) which have been authorized but not activitated because of a shortage of qualified teachers.

3. Over and above this shortage of special education teachers is a shortage of vocational rehabilitation counselors. To serve the mentally retarded only, 10 positions were vacant at the time of the study, and were to be filled as soon as qualified counselors became available. It was predicted that, during the next three years, 120 additional vocational adjustment counselors would be needed.

4. A consultant for the Division of Maternal and Child Health, Texas State Department of Health, stated: "It is conservative to estimate that the general nursing staff in local health departments will need to be increased in the next five years if nursing services used in combatting mental retardation are to be improved and expanded."

5. A special report by a nutrition consultant of the same department provided evidence of a shortage in nutrition personnel, another segment of manpower considered to be an important part of the health team for the mentally retarded.

6. Reports from Mayors' Commissions on Mental Retardation in the 58 largest cities in Texas indicated deep concern regarding current and future staffing of community mental retardation centers.

Having confirmed that a shortage of mental retardation manpower is indeed a reality in Texas, the Task Force next considered the question: What can be done about it? The presentation following consists of a series of recommendations, supported by an elaboration on the need and reasons for the remedies proposed.

Texas school children at an early age should be exposed to information about the "helping professions," and what people in these professions do to help the mentally retarded.

It is recommended that public and private schools be encouraged to incorporate in their programs, from the first grade on, material that would provide knowledge and create interest in the "helping professions."

For example, elementary school readers could contain stories that broaden children's understanding and concepts of these professions. On the secondary education level, young people might be encouraged to form organizations such as future nurses associations, future physicians groups, future psychologists (including educational psychology) associations, future special teachers groups including special education for hearing and speech therapists, recreational therapists, etc., and future social workers organizations.

To these groups could come "visiting scientists" from the professional ranks of the mental retardation facilities to serve as lecturers and consultants. Summer work and participation programs for high school and college students within the institutions and mental retardation facilities could and should be expanded. Better communication is needed among people working in the field of mental retardation, particularly in regard to attracting and placing personnel in positions where they function most efficiently.

The State should develop a means for keeping agency staff members and prospective staff members abreast of the latest advances in the field of mental retardation by encouraging staff research projects and work toward degrees and advanced college attainment.

It is recommended that the Legislature be requested to appropriate funds for State agencies serving the mentally retarded, to be used for scholarships, stipends, and loans for the professionaly education of staff members and prospective staff members in such fields as educational psychology, special education, social service and counseling, speech and hearing therapy, medical and dental training, mental retardation planning and research, etc.

A comprehensive, professional study is needed to identify tasks in the field of mental retardation which can be performed by non-professionals, semi-professionals and professionals.

It is believed that such a study also would serve as an extension of "retooling" efforts that are necessary if Texas is to establish the machinery for doing higher quality work in the field of mental retardation. It is estimated that the comprehensive survey needed would require a minimum of three to five years.

It is recommended that funds be requested to study and determine, with cooperation of professional workers in mental retardation, tasks which can be done by non-professionals, those which can be done by semi-professionals, and those which must be done by professionals.

Continuing and expanding cooperation between facilities for the mentally retarded and the State's institutions of higher learning should be encouraged.

It is recommended that all possible avenues be opened to greater cooperation between the facilities for the mentally retarded and the colleges and universities of Texas. Such cooperative efforts should include making possible dual appointments of persons qualified to render service to both areas: utilizing teaching capabilities of institutional employees in college classes and the consultant services of college and university personnel in the mental retardation programs; providing office and work space in the schools for the retarded for university professors and students to conduct studies and research; encouraging thesis and dissertation efforts in the field of mental retardation; entering into joint efforts for scholarships and training arrangements for institutional employees to get advanced college training; encouraging the holding of seminars and training sessions for employees of depart-

ments and agencies dealing with the mentally retarded, to be conducted by personnel from the institutes of higher learning.

Another important consideration for manpower development discussed in the planning study was the need for a more flexible and functional State Employees Classification Plan.

It is recommended that the State Employees Classification Plan be made more serviceable. The following procedures are recommended:

1. Authorizing employment above the starting (or minimum) salary step for persons who have broad experience, specialized training or noted performance in their fields of work.

2. Providing for a general review and re-evaluation of all positions related to mental retardation in order to attract and retain qualified personnel.

3. Providing for a salary increase for persons completing recognized training programs designed to increase their proficiency and skills.

The very effective volunteer program and services provided by the volunteers in schools and centers serving the mentally retarded in Texas should be recognized and strengthened.

It is recommended that the Texas Department of Mental Health and Mental Retardation initiate studies aimed at strengthening the volunteer program in all services to the mentally retarded and determining additional services which might be provided by volunteers.

9. RESEARCH FOR BETTER METHODS OF PREVENTION AND CARE

OVERVIEW

Research implies change. To those who, in their intellectual inquisitiveness, are eager for change and who regard scientific inquiry a necessary process in society, the research method is logical and necessary. To many, however, researchers are not appreciated, their services frequently omitted from long-range planning, and their methods of data-gathering at times even regarded as meddlesome. Those who tend to be satisfied with conventional methods are not inclined to support research endeavors.

It is obvious, however, that research must be written into the statewide plan to combat mental retardation and must be pursued vigorously if implementation of the plan is to be realized.

The President's Panel on Mental Retardation in 1962 stated: "It is essential to support the foundations of scientific research in all fields, and to stimulate the communication of both needs and solutions among investigators and clinicians working at every level and in all phases of the field, including education, treatment, and care of the retarded." Among recommendations made by this body were: (1) High priority given to developing research centers on mental retardation at strategically located universities and institutions, (2) experimental research findings tested in service agencies before widespread application, (3) development of a comprehensive continuing program for the collection and analysis of population statistics on the incidence, prevalence, and personal and socio-economic characteristics of the mentally retarded (this referred to a Federal program, but the cooperation of states would be imperative), and (4) provision for universities to offer opportunities for research training in several disciplines such as education, psychology, sociology and physiology.

A subgroup of the President's Panel, the Task Force on Behavioral and Social Research, reporting in 1964, spelled out some of the major areas of research that could well be implemented and expanded in the universities, agencies and service facilities of Texas. These included research on such subjects as basic behavioral development, communication, perception, personality, motivation, latent ability mobilization, adjustment of adults, cross-cultural studies, impact on families and community, and the whole broad field of pre-school and school-age educational techniques.

RECOMMENDATIONS FOR STATE COORDINATION OF RESEARCH

It is recommended that the State of Texas provide necessary funds specifically for research projects on mental retardation.

In order to achieve the needed research in adequate scope and with effective priorities, there must be the proper combination of qualified people, coordinated agencies and dependable funding (men, machinery, and money). This would best be done under the control of a properly qualified agency.

It is recommended that the State provide the leadership and the coordinating personnel to pull together researchers, State agencies and universities to obtain maximum use of research facilities in mental retardation.

It is recommended that the proposed State Interagency Council be requested to operate a clearing house for research which would avail itself of published research reports from such sources as the U. S. Department of Health, Education and Welfare: the National Association for Retarded Children, the Council for Exceptional Children, and similar sources, and which would distribute these reports systematically to active research centers in Texas. This Council also should be requested to collect similar publications *from the Texas research centers and distribute them among the several centers in the State.*

CURRENT STATUS OF RESEARCH ON MENTAL RETARDATION IN TEXAS

During the course of the Texas Mental Retardation Planning Study (1965-66) a questionnaire on "Current Research on Mental Retardation in Texas" was sent to the presidents of Texas colleges and universities. Questions were asked concerning research projects starting in the near future. Respondents were asked to include the titles of research studies, amount of funds involved, and names of sponsoring agents.

The research questionnaire was sent to 84 colleges and universities and replies were received from 80 of those institutions. Seventy-one respondents indicated that they had no research on mental retardation in progress or proposed. Nine reported that they were active in one or more such projects, involving 142 researchers and a total cost of $1,287,087.

Higher education institutions and their branches conducting these projects were Southwest Texas State College, San Marcos; The University of Texas Southwestern Medical School, Dallas; East Texas State College, Commerce; Baylor University, Waco; Baylor Medical School, Houston; Vocational Rehabilitation Regional Research and Training Center, The University of Texas, Austin; Special Education Department of The University of Texas, Austin; The University of Texas Medical Branch, Galveston; Texas Woman's University, Denton. Current research on mental retardation at the Houston State Psychiatric Institute was also reported in this survey.

The questionnaire data indicated that the six State Special Schools currently have research projects totaling $2,066,243 in progress. Development and training grants now in operation in the State Schools total $935,115.

SPECIFIC AREAS OF NEEDED RESEARCH

Although some excellent research on mental retardation is being performed in Texas, it was felt that much more research should be planned and conducted on all significant aspects of mental retardation.

It is recommended that priorities be established for research projects on problems in mental retardation which are relatively unique to the State of Texas. Priorities recommended by the Task Force on Research were (1) *Descriptive statistical data;* (2) *Education and treatment;* (3) *Preventive aspects of mental retardation;* (4) *Subcultural, economic and ethnic factors in mental retardation; and* (5) *Georgraphic problems. (More detail on each is presented below.)*

1. *Descriptive statistical data*. Epidemiological data and educational and treatment data on mentally retarded in Texas should be assembled, categorized and tabulated on computerized cards for storage, retrieval and use by all agencies and research centers. Once assembled, these data should be kept current. The State of Texas should maintain a staff to carry on this work within the framework of an existing agency (e.g., the Texas Department of Mental Health and Mental Retardation, Mental Retardation Division).

Such data should be compiled from all State agencies handling retarded children and adults and from private facilities such as: parochial schools, private schools for retarded, chapters of the Texas Association for Retarded Children, Community Welfare agencies, community special agencies and organizations, Goodwill Industries, crippled children's services, camps and summer recreation facilities and others.

An individual record on each retarded person should be submitted with data adequate for computer treatment to include such items as: name, birthday, place of birth, race, address, school district, type of handicap or handicaps, parents' occupation, employment status of mother, number of siblings, test scores, prenatal, paranatal and postnatal attention, midwifery delivery, age of mother at delivery, broken-home status, and other data useful to teachers, therapists, rehabilitation counselors, health and welfare personnel, and college researchers.

A clearing house, furthermore, should be established for amassing other significant data on mental retardation. The data should be derived by well-controlled surveys and should include such factors as incidence, according to geographic areas, ethnic groups, socio-economic levels, and clinical types.

2. *Education and treatment*. Research related to improved methods of education, including habilitation and treatment should be given high priority. Studies on improved methods of educating, grouping, diagnosing and financing

are immediately needed. Research on improved treatment methods in and out of institutions needs to be expanded.

3. *The preventive aspects of mental retardation.* This includes genetic, prenatal, paranatal and postnatal causitive factors such as chromosomal abnormalities, consanguinity, maternal infectious disorders, blood incompatibilities, infant and child care practices, postnatal infectious disorders such as encephalitis, toxic agents and other factors causing brain injuries.

4. *Subcultural, economic and ethnic factors in mental retardation.* These factors present numerous problems unique to Texas such as those found in bilingual and migrant subgroups. Some of the important problems needing investigation under this category are: effects of malnutrition and lack of environmental stimulation; the incidence and effects of poor infant and child-care practices, such as midwife delivery; effectiveness of preschool learning experiences; and methods of increasing motivation or achievement drives. (These data might be obtained, in part, from the Texas Mental Retardation Planning Study.)

5. *Geographic problems.* Research should be performed in the State on problems unique to particular geographic areas. This would include the sparsely settled areas of west and southwest Texas and rural versus urban problems.

PROPOSED EXPANSION AND CREATION OF RESEARCH INSTITUTES FOR RETARDATION

Mental retardation research, as well as mental health research, involves an extremely wide range of scientific disciplines, methods of investigation and points of view as to the nature of the problem. This fact was borne out by the research committee which produced recommendations for a comprehensive mental health program for the State of Texas, many of which were implemented in The Texas Mental Health and Mental Retardation Act, passed in 1965 by the 59th Legislature.

Under section 2-18 of this Act, entitled Research Institutes, it is stated that:

> "(a) The authority for the operation of the Houston State Psychiatric Institute for Research and Training is transferred to the Department.
>
> "(b) The Department may establish research institutes devoted to research and training in support of the development and expansion of mental health and mental retardation services in the State. The research institutes may be affiliated with major medical centers, medical schools and universities of the State.
>
> "(c) The Department may accept gifts or grants of land and make contracts for the construction of buildings and facilities at any site selected for the location of research institutes, or the Department may enter into any contract or leasing agreement with any Federal, State or local agency or with any person or other private entity for the use of buildings and facilities.
>
> "(d) The Department may administer and operate research institutes with funds donated by Federal, State, and local agencies, and by persons and other private entities and with any money that may be appropriated by the Legislature."

In keeping with these provisions of the Texas Mental Health and Mental Retardation Act, the following recommendations are made:

It is recommended that provisions be made for the further strengthening and diversifying of research activity at the Houston State Psychiatric Institute, which already has been designated (in House Bill 3) as the official center for research and training for the Texas Department of Mental Health and Mental Retardation.

It is recommended that provisions be made for opening a new institute for research of mental retardation and human development.

It is recommended that provisions be made for the development of a center in a University in western Texas for research on mental retardation problems specific to sparsely settled areas.

Additional information concerning each of these recommendations is presented below.

HOUSTON STATE PSYCHIATRIC INSTITUTE

Inasmuch as the research section of the Texas Plan for Mental Health Services was prepared with the fields of mental illness, mental health, and mental retardation in mind, it is felt that many of the areas of research in mental health would be similar to those in mental retardation; therefore, the following recommendations of the research committee on mental health are reiterated here: "The Research Task Force strongly recommends that the State establish additional research institutes similar in organization to the Houston State Psychiatric Institute. It further recommends that Houston Institute be substantially strengthened to take advantage of the excellent facilities of strong nucleus of scientists now given joint appointments in Baylor Medical School and the Institute."

The Houston State Psychiatric Institute should be strengthened and maintained in an atmosphere which is conducive to creative thought. The Institute should encourage activities throughout the broad spectrum of research from basic research through applied research directly related to clinical problems.

PROPOSED INSTITUTE FOR RESEARCH ON MENTAL RETARDATION AND HUMAN DEVELOPMENT

Funds now have been appropriated through the National Institute of Child Health and Human Development for support of research centers on mental retardation and human development. Construction money is available on a 75 per cent Federal, 25 per cent State matching basis.

PROPOSED INSTITUTE IN WESTERN TEXAS FOR RESEARCH ON EXPERIMENTAL PATTERNS OF PATIENT CARE AND MENTAL HEALTH SERVICES IN SPARSELY POPULATED AREAS

As pointed out in the Texas Plan for Mental Health Services, too often the research programs in mental health neglect the special problems and unique opportunities that exist in rural areas and smaller towns and cities. The kinds of mental health services and the patterns of patient care that prove satisfactory in large metropolitan areas simply will not work when transplanted to sparsely populated regions unless altered to fit the special needs of rural populations. A research institute should be established in western Texas to undertake research and demonstration projects evaluating new patterns of mental health and mental retardation services for sparsely populated areas.

10. TEXAS LAW AND THE MENTALLY RETARDED

Recommendations of the various Task Forces which might require new laws or changes in present laws are explained in some detail in this section. The recommendations of other Task Forces may require only adaptations or better administration of programs under present laws. These matters also are treated specifically.

INTRODUCTION

Background. Laws alone do not prevent mental retardation, diagnose cases, house, train or educate patient-students; support research, or always assure the proper handling of mentally retarded persons accused of crime.

Law is slow to change, partly because the enactment of new statutory law is a laborious process and therefore the statutes remain relatively rigid despite changed conditions, and because the development of case law by courts is the result of the application of statutes to an almost infinite variety of situations, few of which can be chosen in advance to obtain a desired result.

This slowness to change is mentioned because, traditionally, abrupt and massive departures from existing law are rare. Productive and worthwhile changes have tended to be evolutionary rather than revolutionary. Everyone interested in the well-being of mentally retarded persons should know that the law changes slowly. This should be taken into account in planning the best programs possible. Building on present law is usually much easier than bold new departures. In meeting social needs, law is only one of three elements. To produce protection, or services to be rendered in the governmental sector of our society, the three essentials are law, funds and staff. It takes all three to have program.

Philosophy. The Task Force on Welfare stated that it believes mentally retarded persons have the same needs, hopes and wants as normal persons. That philosophy was endorsed by the Task Force on Law.

In every area of personal need for services and protection, there is a higher degree of acuteness among most retarded persons because of their relative lack of capacity to cope with the activities and pressures required for existence and growth in modern society, particularly in Texas' heavily urbanized society.

Principles. Careful consideration has been given to the recommendations coming from the local Mayors' Commissions. This section also has benefitted from the reports of the other Task Forces, aid of the research staff, and free and frank discussions among its members.

If all of the recommendations and responses are carefully sorted out in tenor and in substance, they tend to cluster around two themes:

1. Responsibility should be fixed.
2. Responsive solutions should be found.

These two themes can be shortened to single words: Responsibility and Responsiveness. Neither is a purely legal term. Insofar as possible, however, the report and recommendations of this section will refer to specific problem areas and the concept of desirable solutions in that frame of reference: Responsibility and Responsiveness.

WHAT IS INVOLVED

This section will not deal with every problem posed by the large numbers of mentally retarded persons. It is an acknowledged fact that these persons reside in almost every community in Texas, certainly in every county. They have a spectrum of needs, and in line with the two cardinal principles of Responsibility-Responsiveness, it is felt that the following overall considerations are involved in the area of the law and the mentally retarded persons in Texas.

Individual responsibility. Individual responsibility should be visited upon the mentally retarded person—so far as he is capable—but no more. Actual mental retardation is a chronic and irreversible condition usually characterized by mental and social development to a plateau of understanding and achievement somewhat below "normal." The responsibility of a mentally retarded person in all civil matters should track his respective mental capacity. What to do when criminal responsibility is involved is less clear. This entire area is treated at some length under Part 2, below, "The Mentally Retarded and the Criminal Law."

Familial responsibility. The family of a mentally retarded person should assume responsibility for him to the best of its capabilities, but not beyond those reasonable for the family's resources and station in life. Texas laws require parents to support their children, and to support their mentally retarded children in State Schools if able to do so. In cases of divorce, the father may be required by law to pay for the support of a mentally retarded child without regard to the child's age. This is considered to be a wise provision.

Governmental responsibility. There is a wide scope of governmental responsibility for mentally retarded persons. The bulk of the services for mentally retarded persons in Texas comes from:

1. The State Schools. (Texas Department of Mental Health and Mental Retardation.)
2. Special education classes in public schools. (Texas Education Agency.)
3. Aid to the totally and permanently disabled. (Texas Department of Public Welfare.)
4. Cooperative programs for vocational rehabilitation. (Texas Education Agency.)

Because local governments are creatures of the State and because some local governments either may not do, or may hesitate to do anything in the way of governmental action without a specific enabling law, it seems that—legally speaking—the key to helping the mentally retarded citizens of Texas lies in State law and State-authorized financing.

This reference would not be complete without paying tribute to the many ways in which the Federal government aids the mentally retarded: research, funding of PKU (Phenylketonuria) testing programs, aid to welfare programs, underwriting planning efforts in all states similar to the Texas Mental Retardation Planning Study, etc. Because the Federal laws are, in general, outside the scope of this report, however, they are not treated in detail here. Some recommendations involving Federal Law and aid from the Federal government are included, however, in the endorsement of S.J.R. 33 (59th Texas Legislature), to be voted on in November, 1966, as Proposition No. 15.

THE SITUATION TODAY: TEXAS LAW AND THE MENTALLY RETARDED

A one-word description of Texas law today with regard to the mentally retarded person is "spotty." Many aspects of the law impinge directly or indirectly upon the mentally retarded person. To deal with this problem in a meaningful manner, it is necessary to categorize. The classifications chosen here are wholly arbitrary and do not, of necessity, encompass all of the problems or even every phase of every program, being more in the nature of examples.

1. *Prevention*: Texas now has a law making the testing of newly-born infants for PKU (Phenylketonuria) mandatory. (Art. 4447e.)
2. *Education*: Texas school laws define mentally retarded persons for special education purposes, and policy directives distinguish among degrees of retardation.
3. *Guardianship*: Texas has no special laws for the guardianship of mentally retarded persons. It is believed that the present guardianship laws, if rigorously and uniformly applied, are adequate.
4. *Institutional Care*: Texas law sets up several State Schools for mentally retarded persons and provides a general statute for their admission to those schools. This admission Law is Article 3871b.

RECOMMENDATIONS FOR IMPROVEMENT

The recommendations in this section are divided into two parts. Part I is an item-by-item analysis of some of the recommendations from the other Task Forces and the 58 Mayors' Commissions involving changes in the law. Part 2 is a consideration of problems revolving around the mentally retarded person accused of crime or delinquency. To some extent, Part 2 will be repetitious of Part 1, in that it will be a summary of the conclusions reached by the Law Task Force.

PART 1: RECOMMENDATIONS INVOLVING CHANGES IN TEXAS LAW

TASK FORCE	RECOMMENDATION	LEGAL CHANGE REQUIRED
Education	Preschool services needed.	Could be done in special kindergarten, would be necessary to amend Art. 2919 now requiring an election to establish any kindergarten.
Education	Regional diagnostic and consultative agencies for "spectrum" of services to the mentally retarded.	This might be possible by amendment of the Rehabilitation District Law, Art. 2675k; otherwise by new legislation.
Education	Allow allocation of special education coordinators in districts with 10 to 21 special education teachers.	By amending Art. 2922-13 and 2922-12.
Education	Amend the special education teacher allocation formula to a straight classroom teacher unit for ten special education pupils; allocate funds on basis 1 pupil equals 1/10th unit allocation.	By amending Art. 2922, 2922-12 and 2922-13.
Education	Mandatory participation of district in special education to assure services.	By amending Art. 2922-11 or 2922-13.
Education	If local services not available, transportation costs to be paid to district rendering services.	By amending Art. 2922-15.
Education	Special education teachers to be reimbursed on an eleven month basis.	By amending Art. 2922-14.
Education	Employment of education diagnosticians, 12 month basis to work with persons with learning difficulties.	By amending Art. 2922-12.
Vocational Rehabilitation	Funds should be made available for complete evaluation of all children in cooperative school-rehabilitation program.	Amendment of Art. 2922-13 or 2922-15.

TASK FORCE	RECOMMENDATION	LEGAL CHANGE REQUIRED
Vocational Rehabilitation	Transportation of mentally retarded clients to and from agency facilities.	Declaration of such transportation as a governmental function and appropriation of funds to a local unit of government for this purpose; or law plus funds to be used for contract services.
Welfare	Amend Aid to Totally and Permanently Disabled to make payments to parents or guardians of mentally retarded persons who can remain in family setting.	Amendment of eligibility under Art. 695a, and revision of the Constitution, Art. III, Sec. 51-a.
Residential and Day Care	Possible establishment of institutions for multi-handicapped persons—blind-retarded, etc.	Legislation establishing facility plus appropriation.
Residential and Day Care	Revisions in the Mentally Retarded Persons Act to permit non-judicial admissions.	Amend Section 9 of Art. 3871b.
Residential and Day Care	Purchase of care plans like Louisiana.	Possible by amendment of the Mentally Retarded Persons Act, Sec. 17, plus appropriations.
Research	State funds be provided for mental retardation research.	None. Added appropriated funds. H.B. 3 is sufficient authority.

The Law Task Force reported that it felt the above recommendations are constructive.

Throughout the various sections, there are at least three central ideas: Planning, Coordination, and Financing. There seems to be little or no division of opinion concerning the ultimate ends in view, or the spectrum of needs of mentally retarded persons. "Who is to do the job?" and "Who will pick up the check?" seems to be the questions. Although an attempt has been made here to state what legislation is necessary to authorize some agency or level of government to do the job, the specific sources of financing are not recommended. Attention is called to the provisions of S.J.R. 33, 59th Texas Legislature, proposing an amendment to Section 6, Article XVI of the Texas Constitution. This amendment reads as follows:

> "Section 6. (a) No appropriation for private or individual purposes shall be made, unless authorized by this Constitution. A regular statement, under oath, and an account of the receipts and expenditures of all public money shall be published annually, in such manner as shall be prescribed by law.
>
> "(b) State agencies charged with the responsibility of providing services to those who are blind, crippled, or otherwise physically or mentally handicapped may accept money from private or federal sources, designated by the private or federal source as money to be used in and establishing and equipping facilities for assisting those who are blind, crippled, or otherwise physically or mentally handicapped in becoming gainfully employed, in rehabilitating and restoring the handicapped, and in providing other services determined by the stage agency to be essential for the better care and treatment of the handicapped. Money accepted under this subsection is state money. State agencies may spend money accepted under this subsection, and no other money, for specific programs and projects to be conducted by local level or other private, nonsectarian associations, groups, and nonprofit organizations, in establishing and equipping facilities for assisting those who are blind, crippled, or otherwise physically or mentally handicapped in becoming gainfully employed, in rehabilitating and restoring the handicapped, and in providing other services determined by the

state agency to be essential for the better care or treatment of the handicapped.

"The state agencies may deposit money accepted under this subsection either in the state treasury or in other secure depositories. The money may not be expended for any purpose other than the purpose for which it was given. Notwithstanding any other provision of this Constitution, the state agencies may expend money accepted under this subsection without the necessity of an appropriation, unless the Legislature, by law, requires that the money be expended only on appropriation. The Legislature may prohibit state agencies from accepting money under this subsection or may regulate the amount of money accepted, the way the acceptance and expenditure of the money is administered, and the purposes for which the state agencies may expend the money. Money accepted under this subsection for a purpose prohibited by the Legislature shall be returned to the entity that gave the money.

"This subsection does not prohibit state agencies authorized to render services to the handicapped from contracting with privately owned or local facilities for necessary and essential services, subject to such conditions, standards, and procedures as may be prescribed by law."

This amendment, to be voted on in November, 1966, is a vital ingredient to the upgrading of programs for the mentally retarded. It is believed to be a constructive amendment and its adoption is endorsed.

PART 2: THE MENTALLY RETARDED AND THE CRIMINAL LAW

Of all areas involving the law and the mentally retarded, the question of how to approach the many problems incident to the criminal law are the most nettlesome. The principle of responsibility to the fullest extent of individual capability—but not beyond—is considered a workable standard. For this to be a workable standard, however, the mentally retarded person's capabilities must be established in a manner which protects the civil rights of the retarded, the public from criminal acts, and the courts from error.

Mentally retarded persons, so far as possible, should be taught to regard the police as friends and not as threats. But even under the best of circumstances, a few of the retardates will commit acts that violate the penal code. When they do, examination discloses that there is set in motion a process which in Texas, is not altogether responsive to the needs in the case.

There is one school of thought that would allow the mentally retarded person to escape the consequences of his act by the application of a type of "McNaughten Rule-for-the-retarded." That is something similar to the defense of insanity in cases of crimes among so-called normal persons. To move to such a rule would not be responsive to the problem because the accused is not mentally ill although he is mentally impaired.

Such a rule would be hard to formulate and would solve no problems, for if such a rule existed, and if it were used as a plea and if the mentally retarded person were acquitted—such a verdict would not, in most cases, be responsive to his needs. Therefore, the methods described below for affording civil rights to the mentally retarded are proposed.

The new Texas Code of Criminal Procedures (Art. 37.07) provides that if a person is found guilty, the judge is to assess the punishment unless the defendant asks that the punishment be assessed by the jury. This Article also states:

> Regardless of whether the punishment be assessed by the judge or the jury, evidence may be offered by the State and the defendant as to the prior criminal record of the defendant, his general reputation and his character.

It seems clear that at this time (after verdict, before sentence) evidence could be introduced to show the actual intellectual attainments of the accused, and it could be shown that he is mentally retarded.

> *It is recommended that in those cases where evidence is intended to be offered to show that the accused is mentally retarded, either during the trial or after the verdict has been rendered, defense counsel be uniformly encouraged to file the requested sworn motion for probation in felony cases before the trial commences, as provided in Art. 42.12 (b), and similarly in misdemeanor cases under Article 42.13 of the Code of Criminal Procedure.*

Parenthetically, the Law Task Force felt that a pre-sentencing mental and physical evaluation and investigation, to determine the presence or absence of mental retardation, should be within the discretion of the trial judge in every criminal case, whether the issue of mental retardation is raised during the trial or not, or on the hearings after verdict and before sentence and judgment. If the judge is to hear the results of the evaluation, he could weigh them in assessing the penalties.

One Mayor's Commission recommended that funds be available for a thorough pre-trial examination of the defendant at the request of the defendant's attorney or the attorney appointed to defend the accused to determine whether or not he is in fact mentally retarded. This is deemed a suggestion worthy of consideration, provided that the results of the examination were made available equally to the State and the defendant.

> *It is recommended that provision be made for a pre-disposition mental and physical evaluation of every child handled as a delinquent.*

> *It is recommended that provision be made for specialized facilities (a new institution or establishment of special wards at present institutions) for the handling of delinquent retardates or retardates convicted of crime.*

> *It is recommended that provision be made for adequate parole services for adult retardates after released from department of corrections installations or special facilities.*

The Law Task Force did not attempt to formulate a cost estimate for the special facility for delinquent juvenile retardates or for such an institution coupled with facilities for retardates who are chronologically adults and convicted for crime.

Section 2.18 of House Bill 3, the Texas Mental Health and Mental Retardation Act (59th Legislature) authorizes establishment of research institutes in mental health and mental retardation. Sec. 3.13 of the same Act authorizes community centers to conduct research in support of their programs and services. It is felt that a general statute permitting the Texas Department of Mental Health and Mental Retardation to engage in research would be a constructive measure.

11. LOCAL ACTION AND PUBLIC AWARENESS

Local communities of Texas should accept increasing responsibility for identifying needs and providing services in mental retardation. Local action is the key to the success of the Texas Plan to Combat Mental Retardaton. Responsibility for public awareness should be shared at the State and local levels. Coordination of efforts is essential. State-level action is necessary to encourage and assist local programs. Conversely, local-level support and promotion is mandatory for the implementation of statewide programs, facilities and services.

Findings and recommendations of various Task Forces in the Texas planning study point up definite areas of responsibility which must be borne or shared at the State and local levels. These recommendations are adopted to the extent that:

1. State-level workers should inform local workers of all of the recommendations of the Texas Plan.

2. Local workers should do everything possible to assure the implementation of the recommendations.

Although the Texas study indicated that some communities are more advanced than others, it seems that none is assuming its full share of responsibility for combatting mental retardation and helping the retarded.

It is recommended that State-level responsibilities outlined by this task force be assumed by the appropriate State agencies with responsibilities in these areas.

Local action and public awareness are interlocking functions, but for the purpose of implementing the Texas Plan to Combat Mental Retardation, specific goals can be set. In all endeavors to attain these goals, emphasis should be placed on the following assumptions:

1. Local services are more effective and desirable in most instances than State institutional services.

2. Avoiding or alleviating the problems of retardation will pay, rather than cost, in the long run.

3. Most retarded persons can become assets rather than liabilities to their communities.

It is recommended that local-level responsibilities be shouldered by Mayors' Commissions on Mental Retardation, local units of the Texas Association for Retarded Children, and other interested groups and individuals at the local level.

The Texas Mental Retardation Planning Study has demonstrated a need for concerted action in the directions of: (1) General public awareness; (2) community leadership awareness, and (3) parent and special-interest awareness. These three categories of public awareness needs will be outlined below, with each divided into State- and local-level responsibilities.

GENERAL PUBLIC AWARENESS

It is recommended that the target of action for general public awareness be to inform the public generally about the Texas Plan to Combat Mental Retardation, the scope of the problem of mental retardation and what is being done about it, and to create a climate of public understanding and support in which the goals of the Texas Plan can be more easily attained.

It is recommended that State-level responsibilities for general public awareness include the following activities:

1. Prepare new releases for the wire services, (AP, UPI) and work with wire service newsmen on stories of statewide interest on mental retardation and the Texas Plan.

2. Prepare news releases and distribute them to local-level chairmen or representatives.

3. Prepare and distribute radio and television spot announcements.

4. Prepare and distribute model scripts suitable for adaptation on community public affairs programs, and consider producing TV tapes which could be used "as is" or enlarged upon for broadcast by local stations over the State.

5. Prepare fact sheets of a broad, general nature about retardation and the Texas Plan, and suggested speech outlines, and distribute these to local-level chairmen. Consider producing film slides and movies suitable for presentation before organizations.

6. Prepare a pocket-size leaflet giving capsule facts on mental retardation for distribution upon request from local authorities.

7. Make available billboard posters and other display materials promoting the fight against retardation and work through outdoor advertisers and local-level workers in getting them used.

It is recommended that local-level responsibilities for general public awareness include the following activities:

1. Make personal contact with executives and reporters for newspapers, TV and radio stations.

2. Adapt State-prepared news releases for use at the local level and take them to the media. (See the "Fact Sheet for Public Awareness" presented at the end of this section.)

3. Organize a Speakers' Bureau and seek appearances before civic clubs and other groups, using State-prepared facts and texts, and adding local angles. This should be done throughout the year and especially in conjunction with National Retarded Children's Week.

4. Seek time on television and radio community service programs, using State-prepared texts and adding local angles.

5. Distribute State-prepared pocket-size leaflets when speaking before local groups.

6. Ask outdoor advertising firms to use posters on mental retardation.

7. Arrange for programs before Parent-Teacher Association groups to give parents more awareness and understanding of retardation.

COMMUNITY LEADERSHIP AWARENESS

It is recommended that the target of action for community leadership awareness be to create broad-based contributions of volunteer time and money to projects aimed at benefiting the retarded.

It is recommended that State-level responsibilities for community leadership awareness include the following activities:

1. Ask local and county government officials to perpetuate local Commissions on Mental Retardation.

2. Prepare and distribute a priority list of goals set out by the Texas Plan, with emphasis on what can be done at the local level by clubs and individuals.

3. Contact State headquarters of civic clubs, women's organizations, professional associations, etc., to seek support of projects and to relate availability of speakers on mental retardation at meetings of the club's local units.

4. Serve as a clearing house for the exchange of information on support which organizations over the state are giving to projects related to mental retardation.

5. Create a State Speakers' Bureau for appearances before State conventions or professional associations and other gatherings, and seek speaking dates.

It is recommended that local-level responsibilities for community leadership awareness include the following activities:

1. Add a priority list of local goals to the State-prepared list.
2. Form a local Speakers' Bureau and prepare speeches for civic clubs and other organizations to seek financial and volunteer support of specific projects for new or enlarged services. These speeches often may come as a result of interest inspired by talks mentioned above, under "General Public Awareness."
3. Keep the news media informed of any planned speeches, organizational meetings, etc., and invite them to send their representatives.
4. Inform State-level authorities when any project is undertaken or when any club gives tangible support to services or projects.
5. Sponsor open houses at mental retardation facilities and arrange tours for special groups.
6. Compile a list of existing mental retardation services and facilities which need contributions of time or money, and ask for support.

PARENT AND SPECIAL-INTEREST AWARENESS

It is recommended that the target of State- and local-level action for parent and special-interest awareness be to inform parents and those to whom they might turn for counsel, about mental retardation and the services available to them.

It is recommended that State-level responsibilities in increasing awareness of parents and special-interest groups among the public include the following:

1. Prepare a brochure on what mental retardation is, what services are available, and what to do and where to go when retardation is suspected.
2. Distribute brochure and other information to ministers, physicians, county judges, police, county and district attorneys and judges and – particularly in smaller towns – to home demonstration agents, school superintendents or others likely to have professional contact with parents.
3. Prepare news releases with specialized angles for publication in such professional journals as the *Texas State Journal of Medicine* and the *Texas Bar Journal.*
4. Consider placing brochures, which mothers might pick up, in offices of pediatricians.
5. Arrange for speeches by recognized authorities before State medical conventions and other professional gatherings.

It is recommended that local-level responsibilities for increasing the awareness of parents and special-interest groups among the public include the following:

1. In metropolitan areas, create a central source to which parents or others may turn for information when retardation is suspected.
2. Sponsor speeches or seminars for meetings of the local ministerial alliance to inform ministers about mental retardation and thus help them in counseling parents.
3. In larger cities, prepare a brochure on what services are locally available.
4. Distribute State- and locally-prepared brochures to appropriate agencies and professions.
5. Seek to interest newspapers and other media in human interest stories dealing with available services.
6. Organize university - supported seminars for public school teachers, welfare workers and others to help them spot retardation and know where to send children and parents for help.
7. Larger cities should make persons in smaller communities, who might be in contact with parents of retarded children, aware of whatever diagnostic and other

services might be available to them in the metropolitan areas.

LOCAL ACTION

While the increasing of public awareness about mental retardation problems and services, as outlined above, is highly important, public awareness alone is not sufficient.

Local action to add services and facilities, to improve existing services and facilities, and to attain the Statewide goals of the Texas Plan to Combat Mental Retardation is of supreme importance. Local-level support is essential to the attainment of Statewide goals; conversely, State-level assistance is needed in meeting the needs of the retarded at the community level.

Action to provide new or improved services for retardates also will serve to generate public awareness, because it is news when people do things for the retarded, and because people learn more about mental retardation when they become involved with it.

ADDING, IMPROVING LOCAL FACILITIES AND SERVICES

It is recommended that the target of action for local facilities and services be to fill existing gaps in the opportunities available to retardates of all ages to make the most of their limited abilities and to lead fuller lives.

It is recommended that State-level responsibilities for adding to or improving local facilities and services for the retarded include the following:

1. Distribute through the Mayors' Commissions, local units of the Texas Association for Retarded Children and other agencies information as to services and facilities recommended by the Texas Plan.
2. Serve as a clearing house for ideas put into effect or considered by communities throughout the State.
3. Direct communities as to where help (financial, professional and otherwise) is available or might be secured.
4. Send in consultants to help in setting up new facilities or services.

It is recommended that local-level responsibilities for adding to, or improving, local facilities and services for the retarded include the following:

1. Develop a priority list for establishing or improving local programs.
2. Form organizational boards for needed facilities (diagnostic centers, sheltered workshops, etc.) and seek out community leaders to serve as board members.
3. Speak to groups which might support projects financially or in other ways.
4. Keep news media informed of all such efforts; consider appointing news executives to boards.
5. Meet with officials of United Fund or Community Chest to explain and coordinate efforts; seek to get persons sympathetic to the needs of the retarded appointed to the governing boards of these agencies.
6. Ask larger churches to provide special Sunday School classes for retarded children, and ask city recreation departments to offer special recreational programs.
7. Contact school officials and trustees to urge implementation of recommendations of the Texas Plan; seek to assure that newer methods are used in the placing of students and in the instructional program, and that special education teachers attend seminars or do summer postgraduate work to stay abreast of changing methods.
8. In communities having institutions of higher learning, work through administration and board members to implement recommendations of the Texas Plan.
9. Report to the State level on programs initiated or improved, and problems encountered.
10. Arrange for tours of mental retardation facilities for clubs or groups which might give financial or volunteer support.
11. Bring in authorities who might advise

how to establish services or improve existing facilities or methods.

12. Re-evaluate services available to retarded persons from the cradle to the grave in a continuing effort to fill gaps in those services.

13. Larger cities should move in the direction of making services available on a regional basis and inviting the participation of surrounding counties and communities in the establishment and financial support or needed services, thereby making services available to every mentally retarded person in the region.

ATTAINING STATEWIDE GOALS

It is recommended that the target for attaining Statewide goals be to provide grassroots support for services and facilities recommended for Statewide action in the Texas Plan to Combat Mental Retardation.

It is recommended that State-level responsibilities for attaining Statewide goals include the following:

1. Develop a priority list of Texas Plan recommendations for new and improved services and facilities.
2. Draft suggested legislation and work for its passage, keeping local-level agencies and supporters informed of efforts being made, results obtained, and how they can help.
3. Prepare and distribute news releases on these efforts.
4. Implement those recommendations which come within the realm of existing finances and authority, and coordinate efforts among the various State departments.

It is recommended that local-level responsibilities for attaining Statewide goals include the following:

1. Familiarize all workers with Statewide goals.
2. Work closely with State representatives and senators to make sure they understand, and to gain their support for, the recommended programs.
3. In speeches before clubs and other groups (mentioned earlier) ask for support of needed legislation and financing.
4. Make certain administrators and board members of schools and colleges are aware of recommended improvements; seek their positive support of same.
5. Seek editorial support by Texas newspapers of the Texas Plan recommendations.
6. Arrange "Career Day" programs in the public schools, seeking to interest students in careers of service to the retarded.
7. Make sure that local schools and other agencies implement programs, services and improvements authorized by State action.

STATE AGENCY ACTION

A major objective during the next five years should be to create public understanding essential to the establishment of community and regional mental health and mental retardation centers which can take over much of the information-education-referral functions.

This will require additional staff and budgeted funds. If the job is really to be done, and not merely placed on the shelf and labeled the "good, hard work of many sincere people," staff and budget will be necessary.

FACT SHEET FOR PUBLIC AWARENESS

A "Fact Sheet for Public Awareness" was prepared by the State Planning Office for use by chairmen of Mayors' Commissions during the time in which those commissions were surveying their mental retardation resources and unmet needs.

It is recommended that this fact sheet for public awareness and other similar directives deemed appropriate be prepared and distributed to groups and individuals at the local level.

12. ORGANIZATION AND COORDINATION OF STATEWIDE AND COMMUNITY EFFORTS

GENERAL PRINCIPLES

The development of mental retardation services is a multidisciplinary responsibility. Significant contributions have been made by many professions, and the *Texas Plan to Combat Mental Retardation* should foster the fullest possible participation of all relevant disciplines. The planning study emphasized the importance of a multidisciplinary approach to mental retardation and the necessity for administrative and organization strategies recognizing the importance of this approach. Administrative and managerial positions in mental retardation programs, for example, should be filled on the basis of administrative skills and experience rather than on the basis of specific professional degrees.

A great diversity of community needs and resources exists throughout the State. Maximum flexibility of approach, therefore, should be emphasized so that programs will meet the individual needs of those citizens for whom they are designed.

The mentally retarded person should be served, wherever he might be located. Since the great majority of retarded persons live in communities, and since prevention of institutionalization is desirable whenever possible, expansion of community programs is necessary. Texas should be concerned, therefore, with insuring effective coordination of community, regional and State programs through effective administration strategies.

Mentally retarded Texas citizens are served by a number of public agencies, as well as by private programs. To insure maximum returns from existing and future programs, it is imperative that programs complement each other and that they develop to meet the needs throughout the State. Effective administrative procedures must be established to assure the fullest cooperation and coordination among all State and private agencies dealing with mental retardation.

The planning study has revealed a pervasive interest and concern with the problems of mental retardation among the citizens of Texas. A network of knowledgeable and dedicated citizens who could contribute significantly in the implementation of mental retardation programs now exists. We urge, therefore, the inclusion in the *Texas Plan* of strategies to assure the continued participation and involvement of citizens at all levels of programming to the end that maximum contributions by these citizens to mental retardation programs will be fostered.

Recognizing the potential value of multiple source financing for programming, maximum flexibility regarding budgeting of State funds should be the rule, in order to allow the most effective use of such funds to match Federal and/or local funds. Flexibility is particularly desirable in community programs, where services to individual communities or regions must be adapted to the unique needs and resources of each area being served. The primary focus in programming should be on furnishing the best possible services to the retarded, regardless of the source of financing.

INTERAGENCY COUNCIL FOR MENTAL RETARDATION

The multidisciplinary responsibilities extant in the development of services for the mentally retarded require the vital involvement of many State agencies. In order to provide for the efficient and orderly coordination and integration of services, to provide for the evaluation and interpretation of mental retardation programs and needs to the citizenry and to the State government, and to assure the proper implementation of existing programs, an official group representing program interests in the field of mental retardation should be established at State level.

It is recommended that the Legislature be requested to establish by law a standing Interagen-

cy Council for Mental Retardation composed of Representatives of all those State agencies having a responsibility for any program involving services for the mentally retarded.

The Interagency Council would be the primary channel for coordinating communications regarding mental retardation programs among the State agencies directly involved in providing services to the retarded. The Council would strive to minimize areas of overlapping services and to meet needs for the development of services.

The Interagency representatives on the Council should be the chief executives of each agency, acting ex-officio. The Interagency Council should have no direct administrative authority over the various programs represented among the membership on the Interagency Council. Council deliberations leading to consensus decisions and recommendations for action, therefore, should be implemented through the appropriate administrative channels of the agency or agencies having a primary concern.

The Interagency Council should be served by a staff of salaried employees directed by a staff officer directly responsible to the Interagency Council for Mental Retardation. An appropriate budget to carry out the responsibilities of the Interagency Council should be provided. The offices housing staff personnel, equipment, and activities serving the needs of the Interagency Council for Mental Retardation should be maintained separately from and removed from any State agency or department represented on the Council.

POLICY-ADVISORY COMMITTEE

The need for an advisory committee on programs of mental retardation is recognized. The activities of such a committee to assist and advise the Interagency Council in the establishment of policies in such areas as terminology and definition, research, manpower development, guardianships, and the like, can be of inestimable value to the Council in the interpretation of probable reactions and sentiment and in the representation of voluntary organizations with primary interests in the field of mental retardation and related professional programs. Adequate funds should be budgeted to cover consultant fees, travel costs and per diem expenses for committee members.

It is recommended that the statute providing for the establishment by law of a standing Interagency Council for Mental Retardation include provision for the appointment of a policy-advisory committee to be composed of six persons with interests in the field of mental retardation to render advice and to work with the Interagency Council on matters relating to major policy questions involving programs for the mentally retarded.

The Council should hold periodic conferences with the Policy-Advisory Committee to stimulate direct communications between the two groups.

Ideally, to expedite the efficient coordination and integration of mental retardation activities considered by the Interagency Council for Mental Retardation, the concept of regional or community counterparts of the State level Interagency Council should be developed. The Regional or Community-oriented Interagency Council would foster the coordination and integration of programs below the State level in accordance with the actions of the State Interagency Council. Open channels of communication among the programs serving the retarded at the Regional or Community levels should be maintained as they are maintained at State level through the Interagency Council. In those regions or communities where one or more agencies have no regional representative, the State agency may wish to send a representative from the State central office of the agency or from an adjoining region or community to attend the Regional Interagency Council meeting.

A staff officer at Regional level may be appointed or an employee from one of the agencies represented on the Regional Interagency Council may be designated to coordinate and work with the principal staff officer of the Interagency Council for Mental Retardation at the State level. The Regional or Community level staff officer should work directly with and accept guidance from the principal staff officer of the State Interagency Council.

It is recommended that State agencies represented on the Interagency Council for Mental Retardation establish Regional Interagency Councils, composed of the regional counterparts of the State Level Council.

It is recommended that Mayors, County Commissioners Courts or governing bodies of other appropriate political subdivisions be encouraged to appoint standing Local Commissions on Mental Retardation. Commission members should be selected so as to represent official mental retardation agencies and interests and specific voluntary agencies and interests in the community.

The efficacy of the Mayors' Commissions on Mental Retardation Planning in 58 cities throughout Texas is recognized in the development of the Texas Plan to Combat Mental Retardation. The contributions of the Mayors' Commissions for Mental Retardation in the development of the plan recommend continued community leadership in this area under the chairmanship of a commission chairman to be appointed by the titular head of the governing agency.

Commissions should meet regularly with the Regional Interagency Council, such joint meetings to be coordinated by the Regional staff officer assigned for this purpose.

Each commission should meet periodically with the Mayor, the City Council, and other community officials to discuss mental retardation needs and programs and to stimulate communication and coordination of efforts between State and local programs.

Subcommittees may be appointed by the Commissions to serve special needs, such as the appointment of a subcommittee on employment of the mentally retarded.

The local Commissions should establish liaison and schedule regular meetings with the Board of Trustees of Mental Retardation and/or Mental Health Centers, when such centers are included in the community. It is expected that there will be an overlap among members of the Commissions and the boards of trustees of the Community Centers. The boards of trustees will have administrative responsibility for the Community Centers, according to the provisions of the Texas Mental Health and Mental Retardation Act (House Bill 3, 59th Texas Legislature). The Commission should have an advisory function to the boards of trustees.

The Commissions would keep leading citizens vitally involved with local mental retardation programs. They would facilitate communication among local agencies and local, regional and State programs. They could act in an advisory capacity to the Regional Interagency Councils and to the boards of trustees of Mental Health and/or Mental Retardation Centers.

It is recommended that all State agencies providing services for the Mentally Retarded have resources for program development that would allow them to take full advantage of funds that become available for research, demonstration projects and other services and programs.

13. LEGISLATION AND FINANCE

The Texas Plan to Combat Mental Retardation, presented in its entirety in the preceding sections or chapters of this publication, contemplates a coordinated program of integrated services for the mentally retarded, recognizing a full spectrum and array of services in the broad areas of research and prevention, care and treatment, and amelioration of the problem. *The Texas Plan to Combat Mental Retardation* envisions and recognizes the need to strengthen existing programs and to provide for new and necessary services for the mentally retarded in areas where gaps now exist. Never before has Texas presented a more comprehensive program of services for the mentally retarded, to provide for a lifetime continuum of care as near as possible to their homes. A greater investment, therefore, must be made in existing programs, not only to correct inadequacies and inefficiencies in current activities in the field of mental retardation but also to provide for innovation and for new patterns of care.

Careful planning for the purpose of strengthening existing programs and recognizing the needs in expanding programs in research, prevention, care and treatment, and amelioration in mental retardation is vitally essential to prevent a disproportion of interdependent services. To assume that all services might be developed simultaneously would be impractical, to say the least. The total planning effort, requiring sound financial support, must be aimed at the development of programs on a priority and feasibility basis.

The fluidity and rapidity with which the problems of mental retardation are now being resolved in fields where progress lagged so long precludes establishing a positive program for the legislative and financial support of the broad recommendations extant in the Texas Plan. "What is" and "what is not" become "what used to be" in a moment. To recommend positive legislative needs and positive financial support for a plan not yet in the implementation stage would be both impractical and unrealistic. Positive cost figures are far from available for some of the newer innovations in prevention, care, treatment, and amelioration; and even those costs, which are positive today, may become so victimized by rising and changing cost factors in the fluid market of rising costs for manpower, equipment, and professional services, that a complete revision of budgeted costs would become essential within the next year and prior to the next session of the Texas Legislature. It would seem reasonable, therefore, to wait as late as possible before structuring a legislative plan, taken from the *Texas Plan to Combat Mental Retardation* and contemplating financial support.

The Task Force on Legislation and Finance suggests that there is a need to take a good look at existing State legislation and financial data in the total area of cost supports for mental retardation and recommends that further study, during the period of implementation of the plan, be made in order to provide for improvement in needed and necessary areas of legislation and financial support by the time the Legislature comes into session again in 1967.

Although the primary responsibility for meeting costs of services for the retarded rests with the individual or his family, there must be recognition by the government of the responsibility to discharge society's compassion by financing needed care to the extent that a person might be unable to pay for that community benefit.

The basic principle in an effective comprehensive program of services for the mentally retarded is that the services offered must be geared to the needs of the individual and the community. The extent to which a program of services can impart a feeling of security and well-being for our mentally retarded citizens can be measured by the development and provision of adequate programs and cannot be measured in terms of specific dollar values. The dividends to society, however, as well as the personal dividends rewarding the retarded make the chore worth the effort.

Current programs in the fields of special education and vocational training, as they affect the mentally retarded, have already proven beyond a reasonable doubt the efficacy of expenditures in these areas, resulting in the prevention and amelioration of retardation caused by cultural and economic deprivation, by disease, and by avoidable human suffering.

The Honorable Ben Barnes, Speaker of the Texas House of Representatives, addressing the annual gathering of the Texas Social Welfare Association in Houston in November, 1965, said, "I know that we, as a people with a tradition of Christianity and humanitarian concern for the needs of the unfortunate, are committed to meeting these needs as best we can." To meet these needs, closer coordination and understanding among State agencies can result in a more efficient development of programs of tax-supported services for the mentally retarded, avoiding duplications, and recognizing basic governmental responsibilities by departments. Certainly, the possibility of changes in laws and current practices might be necessary to provide for closer coordination and for a more efficient expenditure of manpower and money at all levels of government.

Multi-source funding is, and will continue to be, a reality, involving the local, State, and Federal levels of government. Multi-source funding, it must be recognized, must be regulated to provide for a proper balance and to assure proper relationships among the governmental agencies concerned.

The Texas Plan to Combat Mental Retardation was built and developed on the concept of community responsibility and community planning. Each of 58 Texas communities developed what, in effect, was an individual community plan to combat mental retardation. Each community determined the greatest needs of that community and which needs would ultimately require the greatest expansion and strongest financial support.

Although immediate and future needs will require the financial assistance of all levels of government, every effort should be made to provide for community support of the mentally retarded, both for the purpose of maintaining ideological responsibilities and for control ot economic resources at the community level. For a community to abdicate this responsibility would be to forfeit the right to those democratic principles provided by our State and Federal Constitutions.

The development of programs of services for the mentally retarded must be justified by the needs of the individual in the community rather than to be based solely on cost and on the availability of funds.

The need for establishing closer working relationships between the State and communities is recognized, and it is recommended that completely open channels of communication become imperative in order to avoid overlaps, duplications of services, and other costly and wasteful practices affecting governmental expenditures. Within the communities themselves, care must be exercised to avoid duplication of services for the mentally retarded to the exclusion of other services which should be offered at the community level but which are not because of the economics of supporting duplicate services.

Selection of those services most practical and feasible—and most needed and necessary—for immediate implementation in a comprehensive mental retardation program requires flexibility of funding to provide for shifting program emphasis from one element of service to another and from one location to another, as programs become more recognizable. The Task Force on Legislation and Finance, therefore, plans its greatest efforts during the implementation period in 1966.

APPENDIX

INTERAGENCY COMMITTEE ON MENTAL RETARDATION PLANNING

Bill B. Cobb, *chairman*, Executive Budget Director, Governor's Office

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Charles S. Eskridge, Executive Director, Regional Mental Retardation Training Center, The University of Texas

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THE 58 MAYORS' COMMISSIONS ON MENTAL RETARDATION PLANNING

Much of the material which went into the Texas Plan was gathered in local planning studies in the 58 largest cities in Texas, by Mayors' Commissions on Mental Retardation Planning. These cities, their Mayors, their Commission Chairmen, and members of their Commissions, are presented below.

Abilene

Mayor: W. Lee Byrd, P. O. Box 60, 79604

Mayor's Commission Chairman: Mrs. T. C. Campbell, 1251 Elmwood Drive

Members of the Commission:

Mrs. Ann Baker, 2241 South 19th Street
Dr. Verna Mae Crutchfield, 3665 Janice
Dr. Charles Foster, 4601 Hartford
Dr. William N. Fryer, 2525 Rountree
Mrs. Claude Grant, 1201 Elmwood
Dr. Pete Palasota, 270 Leggett Drive
Dr. Robert Platt, 856 Highland
Mrs. Frances Standifer, 3317 Green Acres Road
Mr. Harry Walker, Box 993

Alice

Mayor: Cecil S. Carlisle, P. O. Box 119, 78332

Mayor's Commission Chairman: Mr. H. H. Presnall, 1112 Arcadia

Members of the Commission:

Mr. Joe Besse, 300 East Main
Mr. W. W. Farrar, 316 Craig Avenue
Mr. Alfredo Garcia, Jr., 808 South Cameron
Mr. George Kiser, P. O. Box 189
Mr. Jack Linder, 713 Washington
Mrs. Mildred Nunley, 703 Jim Wells
Rev. Thos. H. Parsons, 1317 Northwood
Mr. Gonzalo V. Trevino, 321 South Wright
Mrs. Leila Word, 1108 Hartwell Road

Amarillo

Mayor: F. V. Wallace, 516 East 5th Avenue, 79101

Mayor's Commission Chairman: Mr. Lewis Dodson, 75 Hughes Street, P. O. Drawer 1260

Members of the Commission:

Mr. Robert R. Ashworth, 910 West 8th
Mr. E. M. Blackburn, 315 East 5th, Box 70
Dr. James R. Carroll, 1100 Harrison
Dr. Joel Ray Coker, 1422 Tyler
Mr. J. W. Collins, Vaughn Building
Mr. S. T. (Bud) Curtis, 315 Van Buren
Mr. Manuel B. Edquist, Box 511
Dr. G. Mason Kahn, 417 Austin Street, Box 1971
Mr. Hugh H. Loewenstern, Sr., 415 West 10th
Dr. A. B. Martin, 2201 Washington Street
Mr. Samuel M. (Pat) Murphy, 517 Taylor
Dr. Hugh A. Pennal, 2209 West 7th
Dr. Jaime Quintanilla, 807-B Lamar
Mrs. David Rasco, 2412 Travis Street
Mr. Herbert O. Willborn, 105 Houston Street, Box 2089

Arlington

Mayor: Tom J. Vandergriff, P. O. Box 231, 76010

Mayor's Commission Chairman: Rev. D. Warren Neal, 1104 Lynda Lane

Members of the Commission:

Mr. Milton Barrick, 1311 Hillcrest
Mr. Robert Burnett, 604 Waggoner Drive
Mr. R. P. Campbell, 1519 Camellia Drive
Mr. Ben Collins, 109 Parkview Drive
Mrs. Marvin Corder, 1511 Connally Terrace
Dr. Doyle Lansford, City of Arlington
Mr. Charles Merrill, 2706 Gilbert Circle
Mr. Jim Neighbors, 603 Causley
Mr. Ken Nowell, 728 Highland

Austin

Mayor: Lester E. Palmer, P. O. Box 1160, 78701

Mayor's Commission Chairman: Mr. J. Ed Bridges, Box 3552

Members of the Commission:

Mr. Howard Barr, 4602 Ridge Oak Drive
Mr. William W. Campbell, 4714 Frontier Trail
Mr. Robert E. Canino, 8407 Sequoia
Mrs. Josephine Daniel, 2609 San Pedro Street
Miss Margaret Emswiler, 3805 Stevenson
Mr. L. Lee Hicks, 1600 Fairplay Ct.
Mrs. Mary Holman, 201 West 33rd Street
Mr. Merle Huston, 1400 Lorraine
Rev. Albert F. Jesse, 509 Carolyn
Mrs. Herman Jones, 3303 Greenlee
Mr. A. A. (Bob) Mallas, Jr., 703 Robert E. Lee Road
Mrs. Charles Meisgeier, 2703 Richcreek Road

Baytown

Mayor: Dr. C. L. Liggett, (first part of study), Seaborn Cravey, P. O. Box 6097, 77520 (completion of study)

Mayor's Commission Chairman: Mr. Thomas M. Campbell, 509 Grantham Road

Members of the Commission:

Mr. Robert P. Beman, Jr., 122½ West Defee
Rev. H. O. Bomhoff, 1706 Gillette Drive
Mrs. M. M. Brown, Box 30
Mr. C. G. Caldwell, P. O. Box 425
Mrs. Mary Clements
Mrs. H. J. Cornelius, 308 Burnett Drive
Mr. Dan R. Elkins, Savings and Loan Building
Mr. Phil Wayne Evensberger, Radio Station KWBA, Decker Drive
Mr. Gary Garner, 2002 Washington
Dorothy Harrison, 301 Tri City Beach Road
Mr. W. E. Heaner, 707 West James
Mr. W. D. Hinson, Box 30
Dr. Louis B. Hughes, 414 Harold Lane
Mr. A. N. Johnson, 2610 Virginia
Mrs. Anna Johnson, 220 East Defee
Mrs. Joan Johnson, 3012 Market
Mr. Bob Kalbitz, 505 Williams
Mr. and Mrs. Walter Loflin, 713 Lloyd Lane
Mr. Robert Mansker, 5310 North Redell Road
Mr. Clyde Messiah, Box 30
Mr. Dave Moore, 2 West Texas Avenue
La Jean Morris, 209 LaFayette Drive
Shannon L. Morris, 1209 Decker Drive
Wanda Orton, Box 90
Mrs. Julia Pierson, Box 86
Mr. E. L. Roberts, 2101 New Mexico
Dean Walter Rundell, Box 818
Mrs. Don Teter, 5013 Glen Haven
Audrey Tyer, Box 4, Mont Belvieu
Mrs. Katherin H. Wood, 1302 Olive
Mr. John Woodard, Box 30
Mr. John A. Woodard, Box 30

Beaumont

Mayor: Jack M. Moore, P. O. Box 2827, 77700

Mayor's Commission Chairman: Dr. Monty Sontag, 5195 Oriole Drive

Members of the Commission:

Dr. Byrnes Belk, 3455 Stagg Drive
Dr. Harold Bevil, 3430 Evalon
Mr. Frank Dover, 930 23rd
Mrs. Charles Foxworth, 1755 Bandera Drive
Dr. W. Richard Hargrove, Lamar State College
Dr. E. V. Huffstutler, 820 Neches
Mrs. V. E. Karnes, 1088 Amarillo
Mrs. A. B. Marty, Jr., 3880 Holland Drive
Mrs. F. W. Morrison, Jr., 4460 El Paso
Mr. John Neild, 2770 Fannin
Mr. R. A. Permenter, 1025 Woodrow
Mr. William Phillips, American National Bank
Dr. W. Pierre Robert, Jr., 1230 Longfellow Drive
Mr. C. R. Shimek, 1580 Fairway
Mrs. Albert Spahn, 3520 Wheat Drive
Rep. Will L. Smith, 644 Avenue C
Mr. Arthur Stelley, 3895 18th
Mrs. Marjorie Wagley, Pietzsch Elementary School
Dr. Wilber S. White, 2487 Calder
Mr. Hugh Wright, 255 Clark

Bellaire

Mayor: Robert D. Watts, 308 South Rice Avenue

Mayor's Commission Chairman: Gary Summers, 308 South Rice Avenue

Members of the Commission:

Mrs. A. H. Arnim, 5324 Braeburn
Mr. Ralph Bradley, 5101 Bellaire Boulevard
Mr. Prather Brown, 125 Bellaire Court
Mr. W. L. Burns, 5573 Aspen
Mrs. Lewis B. Coke, 5308 Pocahontas
Mrs. Reubin Coons, 4409 Holt
Mr. Marvin Eaves, 308 South Rice
Mr. Pat Emmott, First State Bank of Bellaire
Mrs. H. H. Frisa, 5606 Whitehaven
Mrs. W. C. Gardiner, 4990 Willow
Mr. W. E. Hamilton, 308 South Rice
Mrs. O. A. Itria, 5324 Pine
Mrs. Nancy Kirk, 4511 Holt
Mrs. G. A. Knudsen, 4811 Tamarisk
Mrs. G. P. Kretzschmar, 4816 Welford
Mr. S. E. Lingo, 4923 Elm
Mrs. S. E. Lingo, 4923 Elm
Mr. James C. McBride, 4525 Evergreen
Dr. Mary Magee, 5123 Evergreen
Mrs. Roland Parker, 5211 Valerie
Dr. Tryon Robinson, 4709 Maple
Mrs. Frank Stamper, 110 McTighe
Mrs. G. O. Summers, 5334 Braeburn
Mr. Jerome Toups, 4528 Oleander
Mr. William M. Tripp, 5315 Jessamine
Mrs. J. W. Weems, 4413 Bellaire Boulevard
Mrs. John J. Wheeler, 5333 Braeburn
Mrs. Charles White, 4537 Wedgewood

Big Spring

Mayor: George J. Zachariah, P. O. Box 391, 79720

Mayor's Commission Chairman: Mr. Jack Y. Smith, Box 1311

Members of the Commission:

Mr. Sam Anderson, Big Spring School District
Dr. Preston Harrison, Big Spring State Hospital
Dr. C. D. Marcum, 901 Main
Mr. Arnold Marshall, 1723 Purdue
Mr. Ray Nichols, c/o County Judge
Mr. R. W. Whipkey, c/o Big Spring Herald

Brownsville

Mayor: Antonio Gonzalez, P. O. Box 911, 78520

Mayor's Commission Chairman: Joan Grotzinger, 1705 West Madison

Members of the Commission:

Mr. Bruce Aiken, P. O. Box 1749
Miss Mary Bomaine, Crippled Children's Clinic, Fort Brown
Mr. Ben Brite, 245 Calle Cenizo
Mr. Robert Brockman, 1623 Yale Avenue
Billie Burton, c/o Greater Brownsville Commission, Market Square
Mrs. Lois del Castillo, 114 W. Park Drive
Miss Celeste Cavazos, 610 West St. Charles
Mr. Fred Celaya, c/o Texas Employment Commission
Mrs. Emilio Colunga, 1624 West Washington
Mr. Cosby Contreras, 5160 Wilson Drive
Judge Oscar Dancy, Cameron County Court House
Mrs. Virginia Garcia, 43 East St. Charles
Sister Mary George, Mervy Hospital, 1040 Jefferson
Mrs. Mary Helen Gonzalez, 504 E. Levee
Mr. Tommy Graham, 1333 Old Port Isabel Road
Miss Hazel Hawkins, 25 Honeydale
Mr. James B. Holton, Jr., 1350 W. Elizabeth
Mr. Gene Hooker, P. O. Box 391
Mr. and Mrs. John Hunter, 1314 St. Charles
Mr. Myrlin Johnson, 717 Bowie
Mr. Gus Krausse, 135 Alice Circle Drive
Mrs. Maude A. Lorance, R.N., Cameron County Health Department
Mr. Juan Lujan, 609 Rio Grande Bldg., Harlingen
Mr. Arturo A. McDonald, c/o Boys Club, 1103 E. Monroe
Mr. Gordan McIver, P. O. Box 391
Mrs. J. W. McMaster, 1165 Parkwood Place
Dr. Horacio Mendiola, 105 W. Elizabeth
Mr. Robert Radius, 115 Holly Lane
Rev. Harry Schuckenbrock, 1200 E. Lincoln
Ruth Spooner, City Clinic
Dr. J. Viada, 105 West Elizabeth Building
Mr. Moses A. Westbrook, 244 Fairfax
Mr. Bert Whisenant, 24 E. Levee
Dr. J. Zavaletta, 825 Palm Boulevard

Bryan

Mayor: Ronald C. Dansby (first part of study), Jack Conlee, City Hall (completion of study)

Mayor's Commission Chairman: Mr. Alton O. Bowen, P. O. Box 953

Members of the Commission:

Mr. John R. Birkner, 2701 Kent, #9
Mrs. Agnes Bowen, 802 East 25th
Mrs. Alton Bowen, 506 Brookside Drive
Mrs. Mary Bradley, 2003 Vinewood Street
Rev. Ray Brezna, St. Joseph Church, 600 East 26
Mrs. Travis Bryan, Jr., 612 South Hutchins Street
Mr. Brooks Cofer, 721 Garden Acres Boulevard
Mrs. L. P. Coffey, 2313 South College Avenue
Mrs. Thelma CoVan, 747 Rosemary Drive
Mr. Marion Crump, Edge
Mrs. Martha Culpepper, 4336 Culpepper Drive
Mr. Jack Currie, 1901 Wayside Drive
Mrs. Roland Dansby, 611 East 29th Street
Mrs. Marty Easterling, 203 South Coulter Drive
Dr. Joe Geppert, 2011 Echols
Mrs. Barbara Gerbert, 1-1-E Hensel Apt.
Mrs. Carolyn Good, 1303 Milner Street, C.S.
Mrs. Inez Grays, 404 North Reed Avenue
Dr. John J. Hall, 411 Brookside Drive
Mr. O. S. Hervey, 4012 East 29th
Mr. Art Herwald, 903 Mitchell Street
Dr. Lannes Hope, 3309 Crane Street
Mrs. Morris House, 2406 Kent Street
Mrs. Topaz Hughes, 711 South Coulter Drive
Mr. Roger Jackson, 4101 Nagie Street
Mrs. Mary Jernigan, 3210 Link Street
Mrs. Mackin Jones, 1622 Oakview Street
Mrs. Madelyn Klintworth, 1620 Ursuline Drive
Sister Regina Marie and Sister Lambert, St. Joseph Hospital
Dr. Carlton Lee, 208 North Coulter Drive
Mrs. Robert E. Long, 2005 Miller Street
Dr. William McCulley, 203 Hensel
Dr. Lamar McNew, 4004 Nagle Street
Dr. Chester Mainecke, 1304 Walton Drive, C.S.
Mrs. Curtis Mathis, 1401 Hoppess Street
Mrs. Charles Myers, 800 South Beck Street
Mr. Stephen Pearce, 207 Tee Drive
Mrs. Bookman Peters, 1110 Edgewood Street
Dr. H. D. Pope, 204 Ehlinger Drive
Mrs. Elsie Ramage, 1618 Jersey Street, C.S.
Mr. J. R. Reed, 700 Lawrence Street
Rev. H. W. Reeves, 1300 East 31st Street
Mrs. Mary Ritchey, 301 Hensel Drive
Mrs. L. E. Stark, 1104 Munson Drive, C.S.
Mr. James Stegall, 901 Kasserman Street
Dr. Walter Varvel, 511 Dexter So., C.S.
Mrs. Harvey Watson, 3401 Sandra Drive
Mrs. Doris Yancy, 900 West 18th

Corpus Christi

Mayor: Dr. James L. Barnard (first part of study), McIver Furman, M.D., 319 Furman Building (completion of study)

Mayor's Commission Chairman: J. M. Sloan, M.D. (first part of study), Dr. Helen Woods, 527 Gordon (completion of study)

Members of the Commission:

Mr. Ted Abbott, Coastal States Gas Producing Company, Petroleum Tower
Mr. R. J. Brauer, Parent Child Guidance Center
Mr. Wilfrid Calnan, P. O. Box 9217
Miss Aurora Cardenas, 4622 Green Grove
Mrs. Hugh Roy Cook, P. O. Box 3625
Mrs. Gretchen Cullins, P. O. Box 9217
Mrs. Alton DeSha, 5630 Nelson Lane
Mrs. Pat Duaine, P. O. Box 3025
Mrs. Bob Finke, 4838 Casper
Dr. George Flood, 527 Gordon
Sister Francis, 901 South Alameda
Mr. Ralph Galvan, 3166 Reid Drive, Suite 4
Mr. Don Hawkins, P. O. Drawer 748
Mrs. Evelyn Higgins, 4401 Kirkwood
Mrs. R. N. Holden, 706 Monette
Mr. Lee Howell, P. O. Box 301
Mr. Alexander W. Hueske, P. O. Drawer 748
Mrs. Wayne Lundquist, 210 Wilshire
Dr. W. R. Metzger, City Health Department
Mrs. Mary Moon, 1810 Howard
Dr. Christopher Morris, 261 Circle Drive
Mr. John Nugent, 833 Wilson Building
Mrs. W. T. Nugent, 1525 Daytona
Mr. Adolfo Pesquers, P. O. Box 9217
Mrs. H. O. Roberts, 320 South Morningside
Mrs. R. R. Robinson, 3509 Austin
Mrs. Allie Roddy, P. O. Box 1622
Mr. Joe Salem, 302 North Chaparral
Dr. Nina Sisley, City Health Department
Mrs. Dorothy Watson, 2508 Morgan
Mr. Ben Williams, 921 Bradshaw
Mrs. George Williams, 4202 Patrick

Corsicana

Mayor: R. G. Reading (first part of study), David Campbell, M.D., 2010 Mimosa Drive (completion of study)

Mayor's Commission Chairman: R. L. Campbell, M.D., 1412 Oaklawn Drive

Members of the Commission:

Mrs. Minnie Cooper, 1462 W. Third
Judge Kenneth Douglas, Courthouse
Mrs. Irene Gardner, 1015 East Collin
Mr. Bill Hay, 2423 W. Eighth

O. E. Hendricks, 312 W. First Avenue
Willie Hodge, TEC, 605 W. Seventh Avenue
Dr. Andrew Megarity, 510 N. 25th
Dr. Will Miller, 1405 Oak Lawn
W. C. Onstott, City Hall
Ned Polk, 1025 N. 24th
Rev. Robert S. Potts, 2015 W. Park
Mrs. Thelma Pryor, 812 W. Seventh Avenue
Judge James C. Sewell, Courthouse
Mrs. T. M. Stokes, 1448 Elmwood
Mrs. Mary Williams, 640 W. Fifth Avenue

Dallas

Mayor: Erik Jonsson, Main and Harwood, 75220

Mayor's Commission Chairman: Mr. Charles G. Cullum, 2533 Hawes Street

Members of the Commission:

Mr. A. J. Airoldi, P. O. Box 35062
Mrs. Inez Anderson, Visiting Nurse Association, 2831 S. Ervay
Mrs. Frank Austin, Jr., 4009 Armstrong
Mr. Bill Baker, Buckner Baptist Children's Home, P. O. Box 18267
Mrs. Margaret Beckner, Southwestern Medical School, 5323 Harry Hines
Mrs. Jean Bentley, Children's Development Center, 3131 N. Pearl
Dr. Lawrence Claman, Child Guidance Clinic, 2102 Welborn
Albert Coates, 1720 Life Building
Glynne Coker, County Welfare Department, 4917 Harry Hines
Mrs. Margaret Cone, Day Nursery Association, 2017 South Ervay
Mr. W. H. Cothrum, 412 Lochwood Village
Mr. Earl Davis, United Cerebral Palsy, 801 Core
Mr. Robert L. Dillard, Jr., Southland Center
Mr. Charles Edwards, 1501 N. Dallas Avenue
Dr. Heinz Eichenwald, Southwestern Medical School, 5323 Harry Hines
Miss Selby Fly, Hope Cottage, 2301 Welborn
Mr. Peter Gaupp, Timberlawn Foundation, 4645 Samuell
Mr. Bernard Goldstein, Jewish Family Service, 209 Browder, Room 403
Mr. James B. Goodson, Southland Life Insurance Company, P. O. Box 2220
Mrs. Wesley Goyer, 5222 Wenonah
Mr. Ludwig Guckenheimer, Bureau of Family Service, 1114 Commerce
Mr. W. B. Helton, Dallas Independent School District, 3700 Ross
Miss Rose Lee Herring, City Health Department, 1936 Amelia
Dr. Edythe Hershey, United States Children's Bureau, 1114 Commerce
Mr. John L. Ingle, 1367 Bar Harbor Drive
Mr. Henry Jacobus, Jr., 6119 Joyce Way
Mrs. Elmer Krueger, 1924 Riverway Drive
Dr. Robert Leon, Southwestern Medical School, 5323 Harry Hines
Mr. George Looney, County Juvenile Department, 4711 Harry Hines
Dr. P. E. Luecke, 4105 Live Oak
Mr. M. L. McDonald, Caruth Rehabilitation Center, 7850 Brookhollow
Dr. Harry Martin, Southwestern Medical School, 5323 Harry Hines
Dr. Jack Martin, Southwestern Medical School, 5323 Harry Hines
Mr. Juan Mason, Dallas Independent School District, 3700 Ross
Mrs. Sophia May, United States Public Health Service, 1114 Commerce
Mr. Kenneth Mills, Caruth Rehabilitation Center, 7850 Brookhollow
Mr. Joe Neuhoff, 2821 Alamo
Dr. Floyd Norman, 4143 Cole
Miss Verlin Osborne, 7850 Brookhollow
Mr. Price Parker, State Department of Public Welfare, Old Courthouse
Mr. W. T. Puryear, Dallas Independent School District, 3700 Ross
Mr. Glen Rollins, HEW, Mental Health Services, 1114 Commerce
Mr. Philip Rushing, National Association for Retarded Children, 202 S. Ervay
Mr. Edward J. Rydman, Planned Parenthood, 3620 Maple
Mrs. Charles Sharp, 5227 Meaders Lane
Mrs. Sam Shelburne, 5543 Waneta
Dr. Joseph H. Siegel, 2618 Oak Lawn
Mrs. Charles L. Smith, 2806 Fairfax
Mrs. L. Storey Stemmons, 6246 Lupton
Mr. Charles Storey, 2700 Republic Bank Building
Mrs. Ted Strauss, 5100 Park Lane
Dr. Robert Stubblefield, Southwestern Medical School, 5323 Harry Hines
Mr. Jack Sudderth, Office of Vocational Rehabilitation, 3515 Swiss
Mr. Durwood Sutton, Grand Prairie State Bank, 200 W. Main, Grand Prairie
Miss Kathleen Varner, Children's Development Center, 3131 N. Pearl
Miss Thelma Whalen, Family Service, 2200 Main
Dr. Wirt M. Wolff, 3503 Fairmount
Mrs. J. Lee Wood, 7011 Meadow Lake
Mr. George Wysong, Texas Employment Commission, 1206 Ross

Del Rio

Mayor: H. Conger Jones, 109 West Broadway, Drawer DD

Mayor's Commission Chairman: Mrs. L. S. Vasbinder, 404 Stricklen Avenue

Members of the Commission:

Mrs. Angela Aguilar, 1206 Ave. B
Mr. and Mrs. Christobal Aldrete, 217 Highland
Mrs. Eulalio Calderon, Jr., 313 E. Bean
Dan Cobb, 6006 Live Oak, Greenville
Mr. and Mrs. Raul Dominguez, 1803 Avenue C
Mr. and Mrs. A. R. Garcia, Bolner Lane
Mr. and Mrs. Tom Garrett, 101 South Broadview
Mrs. Gloria Hermann, 105 Austin Courts
Mr. and Mrs. Hatton W. Honeycutt, 403 Stricklen
Captain and Mrs. Robert Inderman, 9062 B Frazier, L.A.F.B.
Mrs. John W. Keller, 1311 South Main
Mr. and Mrs. J. R. Koog, 1704 Avenue D
Mrs. R. B. Leathers, 1268 Quarry, Eagle Pass
Mr. and Mrs. M. C. Locke, 209 North Main
Miss Lena McCue, 200 Broadway
Chaplain Robert L. Merrill, 9086 Lawhon, L.A.F.B.
Mrs. James Murphy, 106 N. Broadview
Mr. and Mrs. Bill Nixon, 703 Stricklen
Mrs. J. B. Pena, 201 Waters
Mr. Leonard Reyna, Jr., 700 Rio Grande
Colonel and Mrs. Stuart Robb, 9127 Brown, L.A.F.B.
Mrs. Stephen Ross, 410 Johnson
Mrs. Carl Schorr, 222 Fox Drive
Mr. and Mrs. Ted A. Small, 101 North Orbit
Mr. and Mrs. Max Stool, 219 West Strickland
Mr. and Mrs. W. E. Stavley, 103 South Broadview
Mr. and Mrs. Paul Tanksley, 254 West Strickland
Reverend Joe Walts, 509 East Losoya
Mrs. R. D. Weaver, 100 Serafini

Denison

Mayor: W. Worth Campbell, 108 West Main Street

Mayor's Commission Chairman: Mr. Fred T. Reeves, 1314 Lafayette

Members of the Commission:

Mrs. Paul S. Ague, 1108 Oakridge
Mr. Wayne Dodson, 220 North Houston Avenue
Dr. Don W. Freeman, 2301 South Austin Avenue
Mrs. Wayne R. Howell, 711 South Fairbanks Avenue
Dr. A. O. Jensen, 2301 South Austin Avenue
Mrs. C. B. Middleton, 1120 West Morton Street
Mrs. Gladys Overbeck, 1025 South Maurice
Mrs. Claude Rainey, 1225 West Gandy Street
Mr. Norman Talley, 126 East Murray Street
Mr. Everett Weldon, 7265 Lakeview Drive

Mrs. W. E. Wilcox, 1201 Woodlawn
Mrs. Charles W. Williams, Jr., 1515 West Hull Street

Denton

Mayor: Warren Whitson, Jr., 221 North Elm

Mayor's Commission Chairman: Dr. Ernest O. Watkins, Drawer E, TWU Station

Members of the Commission:

Mr. Wayne Autrey, City Hall
Mr. Bill Bingham, Texas Technological College, Lubbock
Mr. Joe Bowers, 610 Hillcrest
Mr. R. L. Breckenridge, Denton State School
Mrs. Margaret Clarke, 806 Greenwood
Mr. Emory Close, High School, Pilot Point
Mrs. Wilma Daniel, Department of Education, TWU
Mr. J. K. Delay, Box 217, Lewisville
Mr. J. A. Hillis, Vocational Rehabilitation Office, Fort Worth
Mr. Reg Holland, 1421 Kendolph
Mr. Alonzo Jamison, 616 West Oak
Mr. Edwin W. Killian, Denton State School
Mrs. Lennis McAdams, 824 Cross Timbers
Mrs. Jane K. Maddox, Denton State School
Mr. Marion Shields, Argyle Public Schools, Argyle
Mrs. Yvonne Messler, 202 North Locust
Mr. Charles Morris, 200 South Locust
Mr. W. C. Orr, First State Bank
Mr. Barrett Reeves, Box 188
Mr. Mike Rummell, Shell Oil Company, Highway 24 West
Dr. Donald Ryan, 2521 Glenwood
Dr. Paul Schedler, 1614 Scripture
Mr. Chester Strickland, Denton Independent School District
Reverend Paul Young, 1915 Locksley

Edinburg

Mayor: Al Ramirez, 107 East McIntyre

Mayor's Commission Chairman: Dr. W. C. Ferguson, c/o Pan American College

Members of the Commission:

Mr. Leroy Eastin, Chief of Police
Mr. John Gross, The Daily Review
Mrs. Gertrude Lake, P. O. Box 990
Mr. Charles Pierce, 1524 South 10th Street
Dr. Charles Queen, 113 South 10th Street
Mrs. David Smith, 609 South 9th Street
Mr. Robert Thomas, 1016 West Schunior
Mr. Romeo Villarreal, 1332 North 14th Place
Mrs. Bert Wolfe, 1034 Fairway

El Paso

Mayor: Judson F. Williams, 500 San Antonio, 79900

Mayor's Commission Chairman: Dr. Chester L. Reynolds, 1501 N. Mesa Avenue

Members of the Commission:

Mrs. Cara K. Adkins, 149 Raynolds
Mrs. Lucy Baca, 4301 Nashville
Mrs. Dorothy Ball, 616 North Santa Fe
Mr. Jesus Bonilla, 333 Cargill
Dr. Ira A. Budwig, Jr., Suite 1-A Medical Center, 1501 Arizona Avenue
Mr. Laurence D. Cornett, 5441 Edmonton Avenue
Mr. Jas. H. Daross, 6542 Mohawk Avenue
Mr. W. Keith Daugherty, 510 South Oregon Street
Dr. James F. Day, Texas Western College
Mrs. Robert H. Given, 4935 Meadow Lark
Mr. J. H. Higdon, 9808 Daphne Court
Mr. Jere Kennedy, 9507 Raleigh Drive
Mrs. Mildred Krauss, 118 W. Missouri Avenue
Miss Amanda Lancaster, 1013 East San Antonio Avenue
Mr. Jack McNutt, 8445 Valdespino
Mrs. Margaret Murillo, 7514 Acapulco Avenue
Dr. James S. Nicoll, 100 West Rio Grande
Mr. Robert H. Palm, 5023 Columbine
Mrs. Louis J. Pepin, 5192 Jarman Road
Miss Champe E. Phillips, 2112 Erie Avenue
Mr. William B. Purse, Jr., 416 Cincinnati
Mr. Conrad Ramirez, 357 Ben Swain Drive
Mr. Woody Richards, 920 North El Paso Street
Mr. John B. Rupley, Jr., 8208 Williamette
Mrs. Edith Zanker, 3410 Morenci Road

Farmers Branch

Mayor: A. A. Airoldi, P. O. Box 14203

Mayor's Commission Chairman: Charles G. Cullum, 2533 Hawes Street

Fort Worth

Mayor: Bayar H. Friedman (first part of study), Willard Barr, 241 West 13th (completion of study)

Mayor's Commission Chairman: George Parker, 300 West Vickery Boulevard, Room 2096

Members of the Commission:

Dr. R. Earl Allen, 2524 Roosevelt
Dr. W. V. Bradshaw, 1800 University Drive
Mrs. Earle D. Button, 3701 Wooten Drive
Miss Mary Crutcher, 5th and Jones
Joe Day, Jr., First National Bank Building
Dr. Virginia Ellis, 1001 Montgomery
Stanley Fishler, Life of America Building
Dr. Harold Graves, 3210 W. Lancaster
John W. Herrick, 1906 Fair Building
Richard Hill, 6266 Truman Drive
H. F. Hopkins, 1000 Throckmorton
Brooks Keller, 400 West Seventh
Miss Jo Kelly, 3210 West Lancaster
Dr. Stephen G. Maddox, 5216 West Freeway
Dr. C. O. Terrell, Jr., 1000 Fifth Avenue
Mrs. Lloyd J. Smith, 7428 Bridges
Mrs. E. E. Searcy, 4028 Collinwood
Dr. E. N. Walsh, 1410 Pruitt

Galveston

Mayor: Edward Schreiber, P. O. Box 779

Mayor's Commission Chairman: Dr. C. David Livingston, U.S. National Bank Building, #419

Members of the Commission:

Dr. Truman Blocker, 1422 Harborview Circle
Mrs. Wynnfried Braud, Third Floor, County Court House
Chief William J. Burns, Chief of Police, 18 San Jacinto
Dr. Robert L. Callison, City Hall
Mr. J. K. Duncan, 824 Avenue D, La Marque
Dr. Morgan Evans, 10 Maple Lane
Judge Hugh Gibson, County Court House
Mrs. Dorothy Morris, County Court House
Mr. Richard A. Prets, 7117 Youpon
Mrs. Arthur J. Trimarchi, 1506 Avenue O
Rev. C. A. Tucker, 4419 Q-½
Representative Ed J. Uarris, U.S. National Bank Building
Miss A. V. Urquhart, 828 Avenue L

Garland

Mayor: Carl W. Cooper, 504 State Street

Mayor's Comission Chairman: Mrs. Robert C. Parsons, 208 West Harvard Drive

Members of the Commission:

Mr. Frank E. Amis, 1121 Lourock
Mrs. Wade Cloud, 824 Woodland
Mrs. W. A. Farr, 125 West Wanda Drive
Mr. Kenneth Fuller, 3713 Darmouth
Mrs. Carol Harber, 265 East Garland Avenue
Mrs. Nancy Iske, 4310 Windsor
Leroyce Jones, 3110 Lakewood Drive
Mrs. Elizabeth Merrill, 1620 Lakeside Drive
Mrs. Nancy Mikkelson, 1602 Marion Drive
Mrs. Billie Mock, 4306 Tynes Way
Mr. Gene Morrow, 4509 Windsor
Rev. Richard Nelson, 622 Wildgrove Drive
Mr. and Mrs. Charles E. Nevil, 1725 Crestridge
Mrs. G. K. Quattlebaum, 2818 Honeysuckle
Mr. Charles Smith, 410 East Monica Drive
Mrs. Billy Wagner, 1425 Nash
Mrs. James W. Whitworth, 1640 Elizabeth
Mr. Donald R. Willis, 2326 Nottingham Drive
Mrs. Steven F. Wilson, 903 Carney Drive

Grand Prairie

Mayor: C. P. Waggoner, 318 Main Street

Mayor's Commission Chairman:
Mr. H. W. Van Pelt, 1817 Virginia Drive

Members of the Commission:

Mr. Billy L. Arnold, 721 Egyptian Way
Dr. William L. Colip, 300 N.W. Second Street
Mrs. Pat Dantzler, 113 Byrd Way
Mrs. Leroy Elton, Training Center, 613 N.W. Seventeenth
Dr. Clyde L. Kresge, Jr., 909 Dalworth
Mr. Arvin Myers, 622 S.E. Eleventh Street
Dr. Lillian Solomon, 909 Dalworth
Mrs. James Vecchio, 2322 Cypress Drive
Mr. L. A. Vernon, 917 N.E. Fifteenth Street
Dr. John O. Wilson, 649 Hinton

Greenville

Mayor: R. L. Warren, Jr., P. O. Box 1040

Mayor's Commission Chairmen:
Mrs. Jay Adkisson, Box 846
Mrs. James Rutherford, 2003 Walnut
Mrs. Frank Stinson, 714 Walnut

Members of the Commission:

Mrs. Nancy Adkisson, 2604 Jones
Miss Suzanne Aldridge, 2019 Park
Mrs. T. B. Aldridge, 2019 Park
Mr. Paul Banner, 2501 Beverly Drive
Mrs. Nell Bearden, 1008 Wolfe City Drive
Mrs. Claud Boose, 4013 O'Neal
Judge Lee Bostick, 3606 Bourland
Mrs. T. A. Bouknight, Jr., 5504 Kayway
Mrs. Amos Buchanan, 3903 Redbud
Mr. and Mrs. Ed Callahan, 2705 Stonewall
Mr. Robert Click, RFD 5
Mrs. Lettie Cobb, Ardis Heights
Mr. Paul Coleman, Hunt County Court House
Dr. and Mrs. F. S. Corruthers, 3714 Lee Street
Mr. Danny Darby, 2402 Avondale
Mrs. J. L. Davis, 1101 Commerce Drive
Miss Lois English, 3910 Wellington
Mrs. George Evans, 4003 Western Circle
Mr. and Mrs. Hal Gammill, 2404 Royal Lane
Mrs. Gracie George, 3004 Lark
Mrs. Arlo Grantz, 2309 Wesley
Mr. Danny Hearn, RFD 5
Mr. M. L. Hulsy, 2604 Jones
Mrs. W. F. Johnston, 4105 Harris
Mr. Jack Maxey, YMCA, 1915 Stanford
Captain and Mrs. David Mickles, 2315 Wesley
Mrs. C. R. Milam, 3016 Bourland
Mr. and Mrs. Roy Milam, 3016 Bourland
Mrs. Louise Miller, 3812 Wesley
Mrs. Virginis Moore, Hunt County Court House
Mr. J. Harris Morgan, RFD 5
Mrs. George Neal, 2509 Broadview
Mrs. W. J. Partin, 3901 Alpha
Mr. Bill Pemberton, 5902 Stonewall
Mrs. Dorothy Porter
Mrs. Nell Powers, 3500 Nashville
Mrs. Gerald Ray, 5903 Stonewall
Mrs. Med Rutherford, 5309 Wesley
Mr. Ed Travis, 6514 Flamingo Road
Dr. C. B. Weis, 2208 Park
Rev. Fred Wolf, 2309 Holsum Circle
Mrs. Jerry Wooldridge, 2609 Highland

Haltom City

Mayor: Marvin L. Ward (first part of study), Virgil Daniels, City Hall (completion of study)

Mayor's Commission Chairman: Mr. John P. Richards, 4928 Sabelle

Members of the Commission:

Mrs. Fay Baker, 3629 London Lane
Mrs. Sadie Duncan, 2301 Thomas Road
Mrs. John Goin, 4703 Fossil Drive
O. B. Guynn, 2908 Carson Street
Mr. Buford New, 4500 Parrish Road

Harlingen

Mayor: M. T. Hodes, P. O. Box 232

Mayor's Commission Chairman: Mr. Stuart S. Jennings, 310 East Van Buren

Members of the Commission:

Mr. Howard Brawley, Jr.
Dr. J. C. Burkholder, 1724 Ed Carey Drive
Dr. Jas. L. Childress, Cameron-Willacy Medical Society, 1710 Ed Carey
County Child Welfare Branch Office, 201 East Madison
Rev. W. R. Eccles, 2214 East Grimes
Obelin Esparza, Juvenile Officer
Mrs. Helen Foehner, American Red Cross, 118 East Tyler
Mr. Antonio Garcia, LeMoyne Gardens Housing Office
Mrs. Dora Garza, Well Baby Clinic, Lon C. Hill Park
Valdemar Gonzalez, P. O. Box 268
Mr. Darrell Hester, 318 East Van Buren Street
Dr. John Huddleston, 506 East Van Buren
Mrs. Frances Hury, United Fund, Harlingen National Bank
Immaculate Heart of Mary School, 412 South C. Street
Mr. Ralph Jennings, Texas Employment Commission, 308 East Harrison
Mr. John Johnson, Licensing Worker, State Department of Public Welfare, P. O. Box 1187
Mr. Ron Lairsen, 113 East Jackson
Dr. Bert Levine, Clarke and Courts Building
Mrs. R. W. Liston, P. O. Box 1905
Mr. Juan Lujan, 609 McKelvey Building
Dr. I. Magana, Harlingen State Adult Mental Health Clinic, P. O. Box 268
Mr. John Morgan, 1409 East Harrison
Dr. L. G. Muniz, 308 South 3rd
Miss Margaret A. Murray, Harlingen State TB Hospital, P. O. Box 592
Mr. Menton Murray, 320 East Van Buren
Mrs. Kurt Naumann, Welfare Family Service, 210 South F. Street
Msgr. Victor Ralph, St. Anthony's School, 10th and East Harrison
Mrs. Robert Ramert, Well Baby Clinic, Lon C. Hill Park
Dr. Albert Randall, 186 North Sam Houston, San Benito
Mr. Ken Rockwell, 1114 East Taylor
Mr. James W. Ross, City Hall
Mr. John Rugaart, Jr., 2415 East Harrison
Dr. Norman Schultz, M.D., 321 South 13th
St. Alban's School, 1417 Austin
St. Paul's Lutheran School, 313 East Tyler
Mr. Alan D. Sturm, Harlingen State Adult Mental Health Clinic, P. O. Box 268
Mrs. Jane Taylor, 1910 Laurel
Dr. John Tucker, 321 South 13th

Mr. Wally Van Wyk, 613 East Harrison
Dr. George Willeford, 1720 Ed Carey Drive, The Children's Clinic

Houston

Mayor: Louie Welch, 900 Brazos, 77300

Mayor's Commission Chairman: Mrs. William H. Williams, 3318 North Braeswood

Members of the Commission:

Mrs. A. S. Badger, 3212 Albans Road
Rev. J. T. Bagby, St. Martins Episcopal Church, 717 Sage Road
Mrs. Robert R. Barr, State Department of Welfare
Dr. Laura C. Bickel, 30 Oakdale
Mrs. Margaret Booker, 9000 Westview
Mr. Frank Borreca, 3410 Montrose Boulevard
Mrs. Doris Brace, 7419 Haywood
Mrs. Leuella Breedlove, 726 West 18th Street
Mr. Britton, Harris County Welfare Department, 301 San Jacinto
Mrs. Betty Cosey, Harris County Probation Department
Mr. Ben Creath, 4396 Harvest
Mr. Richard B. Cron, 2711 Main
Mrs. Cunningham, State Department of Public Welfare, 1018 Preston
Mr. James Dannenbaum, Jr., 3915 Essex
Dr. Murdina M. Desmond, Baylor University College of Medicine, 1200 Moursund
Mrs. J. A. Elkins, Jr., 101 Farish Circle
Mr. Paul Floyd, Melrose Building
Mrs. Everett Fulgham, 5604 Doliver
Mr. J. Grimes, 1500 Louisiana
Mr. Frederick Grossberg, Tennessee Building
Mrs. J. D. Guidry, 1207 Maroby
Mr. Charles Hamilton, 712 Main Street
Mr. James Hamilton, Department of Parks and Recreation, City Hall
Miss Frances Heyck, 6621 Fannin Street
Dr. Austin E. Hill, 1300 Capitol Avenue
Dr. Reba M. Hill, 6720 Bertner
Mrs. N. D. Hines, 5507 Candlewood
Mrs. Nola Hiskey, 12223 Overcup
Mr. Irick, Probation Department
Dr. Richard E. Jennings, 6516 John Freeman Avenue
Dr. Francine Jensen, 1101 Elder
Mr. Burton Jones, 3920 Milton
Barbara Jordan, c/o Judge Elliott's Office, Harris County Court House
Miss Frances Kelley, Mental Evaluation Clinic, Texas Children's Hospital
Mrs. W. H. Knight, 5809 Holly
Mrs. Dorothy Knowlton, 4002 Ella Lee Lane
Mr. Charles W. Leavens, Harris County Welfare Department
Rev. Lawrence Lee, 1111 Lovett Boulevard
Mrs. Roselle Lewis, 1018 Preston Street
Mrs. Lee Lockard, 3800 University Boulevard
Mrs. McGorum, Harris County Probation Department
Dr. A. A. Mintz, 7227 Holmes Road
Dr. and Mrs. Alfred H. Moore, 4019 Fernwood
Mrs. Virginia Norris, 3009 Southmore
Mrs. Alice Nunn, Houston Council for Retarded Children
Mr. Louis Peters, 1811 Lamar
Dr. Theodore R. Pfundt, 6621 Fannin Street
Dr. C. A. Pigford, Health Department, City Hall
Mrs. David Pollan, 5926 River View
Mr. Curtis Posey, 3800 University Boulevard
Mr. Schoenbacher, Probation Department, 61 Reisner
Mr. Edward Scurlock, Scurlock Oil Co., South Coast Building
Dr. Richard D. Slater, 5723 Thrush
Mrs. Lester Smith, 6011 Deepwood Drive
Mr. Paul E. Smith, 1500 Louisiana
Mr. Noah Sparks, Jr., 1500 Louisiana
Mrs. Thane T. Sponsel, 3436 Meadow Lark
Dr. C. W. Thompson, 2117 Dowling
Mrs. Torrence, c/o Jesse Jones Library Building, Texas Medical Center
Mrs. Ruth Urmy, 3726 Portsmouth
Mr. D. D. Uzzell, 627 Euclid
Rabbi Samuel Weingart, 3707 Link Valley
Mrs. Allen Weiss, 7710 Meadowshire
Mrs. Jane Williams, State Department of Welfare

Irving

Mayor: Lynn Brown, 835 West Irving Boulevard, 75060

Mayor's Commission Chairman: Dr. Walter W. Barrett, 2120 McArthur Boulevard

Members of the Commission:

Mrs. Ann Brame, 914 North Glen Vista
Mr. Steve Fellows, 406 Little John
Mr. Glenn Sayles, 2117 Carpenter Freeway West
Mrs. Dohie Start, Board of Education
Mr. Jim Weaver, 1709 Glen Brook

Kingsville

Mayor: Dr. James A. Stockton, P. O. Box 1310

Mayor's Commission Chairman: Donald G. Haggerton, 415 Shelton

Members of the Commission:

Mrs. Alida T. Alaniz, 603 West Ella
Mr. Joe Boring, 424 East King
Rev. C. L. Branch, Military Highway
Mrs. Bill Gill, 625 West Richard
Mrs. Clyde Hailey, 819 West Avenue I
Mrs. Don Hees, 732 West Alice
Mr. John Morrow, 1315 Angle Road
Mrs. Richard Roosa, 1912 Martin Avenue

Laredo

Mayor: J. C. Martin, Jr., 500 Flores Avenue, 78040

Mayor's Commission Chairman: Mr. Porter S. Garner, Station 1, Box 1607

Members of the Commission:

Mr. W. W. Allen, Laredo National Bank
Mrs. John Becknell, 710 Kearney
Mr. Tom Deliganis, Laredo Junior College Library
Mrs. Lorraine Dickey, 500 Arkansas
Mr. Richard Floyd, 2610 Musser
Mr. Mike Garcia, Laredo Junior College Library
Mr. Jimmy Johnson, Texas Employment Commission
Dr. Lauro Montalvo, 1605 Washington
Frances Quijano, 220 Hidalgo
M. J. Raymond, 420 Garfield
Dr. Jos. Schniedler, 806 Matamoros

Longview

Mayor: E. K. Bennett (first part of study), Tom Tilmoth, City Hall (completion of study)

Mayor's Commission Chairman: Mr. D. A. Benton, P. O. Box 1907

Members of the Commission:

Hon. John Allen, c/o Radio Station KFRO
Rev. Robert D. Bankes, 1303 South Mobberly Avenue
Judge R. E. Blount, Gregg County Court House
Mr. Bennett Cooksey, 515 North Court
Mrs. Clark Dingler, 1212 South Fredonia
Dr. Royce M. Floyd, 723 North 4th
Mr. Carroll Graves, Box 2304
Mr. J. W. Hagler, Gregg County Court House
Mr. Donald Henley, 1103 Centenary Drive
Mrs. Ruth Holt, 1503 Hughey Drive
Dr. Bill D. McKellar, 418 South Center
Mr. Bob Maness, 1500 Berry Lane
Dr. Charles F. Mathews, 515 North Court
Mr. Marvin Mikeska, 2201 Hughey Drive
Mr. Dan Muntean, 110 Skyline Drive
Mr. Jake Reeves, 117 Peterson Court

Mr. Jere Ruff, First National Bank Building
Mrs. Joe Simpson, 523 Jones
Mr. Johnny Stone, c/o City Hall
Mrs. Venedia Watkins, P. O. Box 5962
Mrs. LaMartha Wylie, 905 Delwood Lane

Lubbock

Mayor: Max Tidmore, 916 Texas Avenue, 79420

Mayor's Commission Chairman: B. E. Rushing, Jr., P. O. Box 981

Members of the Commission:

Dr. Erie Dell Adams, 3801 19th
Dr. Ted Alexander, 3405 25th
Mrs. Louise Allison, 1105 38th
Mr. Gene Anderson, Armstrong Transfer and Storage, 500 East 50th
Dr. Ted Andreychuk, Psychology Department, Texas Tech College
Mr. Kent Apple, Lubbock Chamber of Commerce, Box 561
Senator H. J. Blanchard, 1607 Broadway
Mr. Clem Boverie, Furr Food General Office, 1708 Avenue G
Dr. Travis Bridwell, Medical Arts Clinic, 1318 Main
Mr. Dick Bunting, Texas Employment Commission, 1602 16th
Mrs. Bea Caddel, Evans, Pharr, Trout, and Jones, Citizen's Tower
Mrs. Cecil Cagle, 3506 43rd
Mr. Owen L. Caskey, Texas Tech College
Mr. J. B. Cassel, 2114 Avenue Q
Mr. J. C. Chambers, 2302 Avenue Q
Mr. Bill A. Chevalier, 2507 66th
Mr. William C. Clark, Lubbock National Building
Mrs. J. D. Donaldson, 3213 42nd
Mr. Duncan Ellison, KLBK-TV, 7400 College Avenue
Mrs. Rodney Goebel, 2308 48th
Mr. Paul Graham, Paul Graham Company, 1501 Avenue N
Alton Griffin, District Attorney, Lubbock County Court House
Mr. Charles A. Guy, Avalanche-Journal, Box 491
Mr. Jerry Hall, Avalanche-Journal, Box 491
Miss Mary Hamlin, City-County Health Department, 1202 Jarvis
Dr. Ishmael Hill, Lubbock Public Schools, 1715 26th
Mrs. Earl Hobbs, 3305 24th
Mr. C. J. Hollingsworth, West Texas Hospital, 1302 Main
Dr. O. Brandon Hull, 1907 Avenue Q
Mrs. Henry Huneke, 3508 52nd Street
Mr. Charles B. Jones, Citizen's Tower
Mr. Charles R. Jones, 1715 26th
Mr. Frank Junell, Citizen's National Bank
Mr. Steve Lewis, 2614 30th
Mrs. John Lott, 3214 44th
Mr. R. B. McAllister, KSEL Radio, East Broadway
Mr. Kenneth May, Avalanche-Journal
Mr. Alex Miller, Miller-Howard Office Supply, 1420 Texas Avenue
Dr. John T. Miller, Great Plains Building
Mr. Jim S. Moore, Great Plains Building
Mr. G. B. Morris, 1715 26th
Dr. J. G. Morris, West Texas Hospital, 1302 Main
Mr. Tom O. Murphy, Hub Motor Company, 901 Avenue H
Representative Bill J. Parsley, Citizen's Tower
Mr. C. W. Ratliff, KLBD-TV, Box 1507
Mrs. Reuby Rhodes, Lubbock Public Schools, 1715 26th
Dr. Roy Riddel, Jr., Great Plains Building
Mrs. Roy Riddel, Jr., 4707 22nd
Mr. Jim D. Rosson, West Texas Advertising, 1319 6th
Judge Rod Shaw, Lubbock County Court House
Mrs. C. E. Smith, 2508 32nd
Mr. J. W. Smith, Citizens National Bank
Rev. William S. Smith, 3321 33rd
Mr. Robert L. Snyder, KCBD-TV, Box 1507
Mr. A. R. Soderstrom, 302 D. Sherman Avenue
Mrs. James Spears, 5005 21st
Mrs. Jack Strong, 3506 28th
Mr. Gordon Thompson, KFYO-Radio, 914 Avenue J
Mr. Jack Thurman, Texas Education Agency, Great Plains Building
Mr. Roy Van Hoove, Lubbock Public Schools, 1715 26th
Mr. Royce Vernon, Texas Education Agency, Great Plains Building
Mr. Charles T. Woodruff, Carroll Thompson School, 14th and Avenue T

Lufkin

Mayor: Jim Waters, P. O. Box 190, 75901

Mayor's Commission Chairman: Mr. S. H. Morrison, Jr., 1707 Allendale

Members of the Commission:

Mrs. L. J. Arnold, 121 Menefee
Mr. W. W. Beaver, P. O. Drawer 1508
Mrs. Joe Beckham, 1106 Crooked Creek Drive
Mrs. Glenn BeLisle, Route 6, Box 376
Mrs. A. E. Broughton, 1408 Copeland
Mrs. Kenneth Childress, 207 Texas Boulevard
Mrs. Ernest Crain, Huntington, Texas
Mrs. A. E. Drew, 1302 Pershing
Mrs. Murphy George, 202 West Dozier
Mr. Robert D. Hamm, 321 Humason
Mrs. John Heyde, 1408 Betty
Judge O. L. Hubbard, 405 Church
Mrs. E. W. Leach, 906 Wildbriar
Mrs. Lynn Metteauer, 905 Markus
Mrs. James W. Peavy, 420 North Raguet
Mrs. William Sheehy, 1522 Turtle Creek Drive
Mrs. Ada B. Smith, 709 Markus
Mrs. Lillie Smith, County Welfare Office, Court House
Mrs. Milton Smith, 419 North Raguet
Mrs. W. W. Trout, 450 Jefferson
Mrs. Jack H. Wade, 718 Frank
Mrs. J. B. Windham, 911 Markus
Mrs. Fred Woods, Route 5, Box 100

Marshall

Mayor: A. Weldon Webber, P. O. Box 698, 75607

Mayor's Commission Chairman: Dr. Waller Ethridge, East Texas Baptist College (first part of study), Dr. Robert W. Stagg, Department of Religion, East Texas Baptist College (completion of study)

Members of the Commission:

Mrs. Albert Agnor, Shreveport Road
Mr. Bill Allen, 511 West Houston
Mr. E. Dean Allen, 1707-A Elsie
Miss Emma Mae Brotze, 513 West Burleson
Dr. Norman Fromm, 502 Warren Drive
Mrs. David Glenn, 2020 Turtle Creek Drive
Mrs. James Googe, 501 East Merritt
Mrs. Joe Goulden, 706 Whetstone
Mrs. Thelma Jarrott, 200 Brownrigg
Mrs. Julien Kennedy, 408 Henley Perry Drive
Mr. Glenn Kost, Marshall News Messenger, 309 East Austin
Mrs. Orin Littlejohn, 1501 Wilson
Mrs. Roy Lyle, Jefferson Highway
Mrs. Otis Power, 309 Woodland Road
Mr. George D. Robins, 2709 South Garrett
Mrs. Demar Therrell, Fern Lake Road
Mr. Tom Walker
Mrs. Lois White, 1602 East Bowie
Mr. Paul Williams, KMHT Radio Station, Jefferson Avenue

McAllen

Mayor: Paul G. Veale, P. O. Box 220, 78501

Mayor's Commission Chairman: Verne Offerman, P. O. Box 3606

Members of the Commission:

Mr. Ted Clifford, Texas Employment Commission
Mr. Ted Hinojosa, 413 North 14th
Mr. Albert Hughes, Mi. 24 N. and Mi. 2 West

Dr. Dexter Jung, 1309 North 10th
Mr. Juan Lujan, 609 Rio Grande Building
Mr. Jim Moffitt, 916 North 9th Street
Dr. Albert Randall, County Health Department
Judge Magus F. Smith, 1501 La Vista
Mr. Calvin N. Snyder, 1113 North 2nd Street
Mr. Romeo Villarreal, South Texas Habilitation Center
Mrs. Doris Williams, 100 North Closner

Mesquite

Mayor: B. W. Cruce, Jr. (first part of study), George Boyce, Municipal Building, 75149 (completion of study)

Mayor's Commission Chairman:
George Boyce

Members of the Commission:

Mrs. George Boyce, 1107 Gus Thomasson Road
Mrs. W. T. Burns, 2636 Mark Drive
Carolyn Chesshir, 1420 Belt Line Road
B. W. Cruce, 300 Riggs Circle
Ben Funderburk, 4232 Motley
David W. Goodwin, 3608 Hogan
Haynes Hanby, 305 Riggs Circle
Miss Reba Henry, 1718 Belmont
Larry Howell, Texas Mesquiter
Mrs. Dee Ingram
Norma G. McGaughy, Recording Secretary
Lois M. Nance, 1331 Tripp Road
Rev. A. R. Osborne, 1200 S. Galloway
Mrs. Ray F. Owen, 809 Lakeside
Dr. Joey Pirrung, 1123 Lakeview
Ralph Poteet, Superintendent of Schools
George R. Schrader, City Manager, City of Mesquite
John Soward, 4400 Oleander Trail

Midland

Mayor: Hank Avery, Jr., P. O. Box 1152, 79701

Mayor's Commission Chairman: H. Wade Whiteley, 2211 W. Golf Course Road

Members of the Commission:

Foy W. Aldrich, 3522 West Shandon
A. C. Ambler, P. O. Box 1144
C. D. Bearden, 3006 Princeton
Dr. Brent G. Blonkvist, 2005 West Wall
Dorothy E. Clader, 1416 Sparks
Mrs. Christine Feagan, 238 Central Building
Dr. John W. Foster, 1803 West Wall
Mrs. Ray Greene, 4616 Storey
Mr. John Gunter, Midland Tower Building
Claudia G. Hazelwood, 2505 Cuthbert
Dr. R. E. Johnson, 3506 Louisiana
Gary Kelly, Gulf Oil Corporation
Mr. LaDoyce Lambert, Midland-Reporter Telegram
Mrs. Boyd Laughlin, 1703 North Main
O. A. McBrayer, 1701 N. Main
James McClatchy, P. O. Box 135
Mrs. Harry P. McClintock, 2200 Harvard
Mr. Charles McElreath, Midland Memorial Hospital
Kenneth Scott, P. O. Box 1230
Dr. and Mrs. R. Preston Shaw, 2109 W. Texas
Jean Starnes, 1603 North C. Street
I. B. Stitt, 801 Lawson
Mrs. Bernice M. Swanson, 2006 Shell
Louis R. Turcotte, 114 Capitol Avenue
Donald J. Vernon, 3703 Roosevelt
Harold Wallace, Chief of Police, Midland Police Department
Jerry Ward, 4307 Country Club
Dr. B. J. Youngblood, 1802 West Wall

Odessa

Mayor: Preston Parker, P. O. Box 3866, 79760

Mayor's Commission Chairman:
James Geiger, 3616 Bonham

Members of the Commission:

Miss Kay Clarke, 3800 Englewood Circle
Mr. Clint Dotaon, Ector County Court
Mrs. Doris Fielden, 3209 East 31st
Mr. Darrell Fishback, 316 Conet
Mr. John Gandy, Jr., 2005 East 11th
Mr. Bob Harper, 305 East 35th
Mr. Bill Holm, 301 Monticello
Dr. R. E. Johnson, 2200 West Illinois
Mrs. T. W. Kane, 1203 East 11th
Rev. W. L. Lee, 3620 Melody Lane
Dr. Carolyn Lewis, 3201 Blossom Lane
Mr. Jack Logan, 2904 Bonham
Mr. Frank Maywald, 1101 Honeysuckle
Mrs. B. J. Pierce, Cielo Vista Apartments
Mr. Jim Reese, 1504 Cumberland
Mrs. John Ben Sheppard, 3107 Windsor
Mr. Bob Smith, 903 West 25th
Mr. Walter Spence, 1511 Spur
Dr. Charles Stephens, 3204 Blossom Lane

Orange

Mayor: James Neal Miller, P. O. Box 520, 77630

Mayor's Commission Chairman:
H. H. Meadows, 611 7th

Members of the Commission:

Mrs. N. J. Athas, 1 Sunset Circle B
Mrs. Peter Bedner, 31 Knotty Pine
Rev. Joseph O. Berberich, 905 Cherry
Mrs. G. W. Bird, 605 Elm
Mrs. W. J. Boyd, 2207 Westway
Miss Maurine Buckner, 300 County Court House
Mr. Bill Butler, 17 West Colburn
Mr. Walter E. Cobb, Jr., Chief of Police
Mr. Frank Coffin, 213 Camellia
Mr. Malcolm Dorman, 200 West Monterrey
Mrs. Jerry Fairchild, #7 Eads
Mr. George Fletcher, Jr., 628 Crepe Myrtle
Mr. Lawrence Gray, 306 West Joyce
Mr. E. M. Gutmann, 2598 North Street
Mr. Carlton Harmon, 308 West Camellia
Mrs. Carlton Harmon, 308 West Camellia
Dr. Key, City County Health Clinic
Mr. Lee Nelson, 541 West Hydrangea
Mrs. Bess Schofield, 2008 West Park

Pampa

Mayor: H. R. Thompson (first part of study), Jim Nation, 2100 Mary Ellen (completion of study)

Mayor's Commission Chairman:
Mrs. Rufe Jordan, Court House

Members of the Commission:

Mr. Ronnie Cross, 403 West Atchison
Mr. Tex DeWiese, 403 West Atchison
Mr. L. J. Edmondson, 126 West Francis
Mrs. Jack Foster, 1228 Williston
Mr. Warren Hasse, Hughes Building
Mrs. Willie Holmes, 523 Sloan
Mr. McHenry Lane, 1815 Williston
Mrs. Nina Spoonemore, 1200 Hamilton
Mr. Charles Vance, 823 West Francis
Mrs. Kay Veale, 2225 Mary Ellen
Mr. John Warner, 1308 Garland
Mrs. R. L. Wyatt, 1109 Sierra

Paris

Mayor: V. E. Stewart, P. O. Box 37, 75460

Mayor's Commission Chairman: Mrs. R. G. Coleman, 746 Church Street

Members of the Commission:

Mrs. Walter Bassano, 2307 Hubbard Street
Mr. Lester Crutchfield, 1878 Hubbard Street
Walter Franklin, 963 - 23 S.E.
Mrs. W. H. Hale, Jr., 2930 Hubbard Street
Mrs. Lawrence Mann, 3110 Dogwood Lane
Mr. Edgar Stone, 1873 East Washington
Mrs. Bill White, 3171 Margaret

Pasadena

Mayor: James L. Brammer (first part of study), Clyde Doyal, 1211 East Southmore (completion of study)

Mayor's Commission Chairman:
William H. Wheeless, Sr., P. O. Box 3208

Members of the Commission:

Dr. George K. Alexander, 2302 Perez
Jim Brammer, 1205 Monroe
Mr. Allan T. Brown, 235 Outlook, South Houston
Mr. Bill H. Coyle, 1408 Acacia
Mr. Amos B. Culbreath, 2731 Hearne Drive
Mrs. George Engelbretson, 3521 Thornwood
Mr. W. H. Ewing, 616 South Tatar
Mrs. C. A. Fort, 2120 Strawberry
Mrs. Tommye Frye, 3209 Albemerle
Mrs. Grace C. Grantham, 507 South Main
Mrs. L. G. Hancock, 2509 South Houston Road
Mrs. Joe W. House, 1906 Jessie Lane
Mrs. Jack Linn, 1808 Lillian
Mr. John McGuire, 407 Cavalier
Mrs. Audrey Martin, 712 South Main
Mr. Dub Mays, Pasadena City Hall
Mrs. R. B. Meyer, 1506 Oaks Drive
Mr. Bill Nunnellee, 9313 Lugary, Houston
Mr. and Mrs. Reynolds Perez, 1202 Madison Avenue
Mr. John H. Phelps, 2101 Strawberry Road
Mr. Weldon Phillips, 2007 Vince
Capt. Harry E. Powell, 1203 Hart Street
Mrs. John Oswald, 2607 Shenandoah
Mrs. Mae Leah Reed, 403 South Walters, Apt. 5J
Mrs. Vernelle Roberts, 4038 Dumbarton
Mrs. Mary Sanderson, 2601 Huntington
Mrs. C. W. Seyer, 320 South Iowa, LaPorte
Mr. Levi Smallwood, 208 South Witter
Miss Sydney Stowe, 1107 South Witter, Apt. 115
Mr. Warren Stutts, 208 East Curtis
Mr. George Thompson, 204 East Broadway
Dr. Curtis Torno, 1029 East Thomas
Mr. and Mrs. Harvey Turner, 210 Tilden
Mrs. H. G. Twaddle, 302 Dunwick
Assistant Police Chief Doug Wilson, Box 1026

Plainview

Mayor: H. B. Hood, P. O. Box 512, 79072

Mayor's Commission Chairman: Mrs. Elizabeth M. Grady, 912 Portland

Members of the Commission:

Judge C. L. Abernethy, Hale County Courthouse
Mrs. Barbara Allmon, 2006 Independence
Riley Armstrong, 2000 West 17th
Bob Brink, 1215 Smythe
Mrs. Shirley Brownlee, 1706 West 11
Dr. Mary Bublis, 1005 West 9th
Mr. Roy B. Carnes, Plainview Schools, Box 1931
Mrs. Pauline Clark, 1006 Borger
Hoyt Curry, Plainview Welfare Department, Box 512
Rev. Arthur Digby, First Christian Church, 910 Kokomo
Mrs. Hugh Etter, Welfare Office, Courthouse
Ken Foreman
Mrs. Delia Hall, Welfare Office, Courthouse
Mrs. Reba Hanna, Welfare Office, Courthouse
Mrs. Jackie Harder, 609 Denver
Mr. Gifford Hodges, Plainview Schools, Box 1931
Jerry Huddleston
Charles Lipscomb, 2209 Joliet
Dr. Joseph Marshall, Plainview-Hale County Health Unit
Clifton Martin, Hale County Department of Welfare, Courthouse
Tommy Montandon, First National Bank, Lockney
Jan Stanley, Child Welfare Services, Courthouse
Dr. Ralph Thomas, 220 St. Louis Street
Royce Vernon, Welfare Office, Courthouse
Ralph Wayne, State Representative, 2005 West 5th
Charlie Young, Box 551

Port Arthur

Mayor: Lloyd Hayes, P. O. Box 1089, 77640

Mayor's Commission Chairman:
Walter Dezelle, Jr., Box 1309

Members of the Commission:

Raymond Armstrong, 4734 Redbird
Miss Pauline Bird, 530 Fifth Avenue
Dr. Richard J. Bourgeous, M.D., 4359 Big Bend Drive
Mrs. Dorothy Spencer Gary, 2247 Fourth Street
Mrs. Helen Glover, 4311 Big Bend
Honorable Roy D. Harrington, 4320 Twin City Highway
Mrs. Thelma James, 3817 Seventh
Rabbi Israel B. Koller, 3939 Third Street
Honorable Carl A. Parker, 449 Trinity
Mrs. G. M. Sims, Sr., 3905 Fourth Street
Mark Smith, 2121 Lakeshore Drive
Col. Ralph Tolve, 3601 Platt
Dr. R. L. Welch, 513 West Thirteenth
Honorable J. D. Weldon, 1937 Ninth Street

Richardson

Mayor: Herbert M. Ryan, P. O. Box 309, 75080

Mayor's Commission Chairman:
Robert W. Porter, 203 Lois Lane

Members of the Commission:

Bill Blair, 851 S. Greenville Avenue
Earl Davis, 1119 Wisteria Way
Dr. William Fackler, 203 W. Tyler
Mrs. Jo Hitt, 400 S. Greenville Avenue
Roger Kraus, 101 S. Sherman
Kerry R. Sweatt, 1013 Pacific
Jack Sudderth, 3515 Swiss Avenue

San Angelo

Mayor: Leon Abbott, P. O. Box 1751, 76901

Mayor's Commission Chairman:
Dr. D. D. Wall, 1434 Paseo de Vaca

Members of the Commission:

Mr. George Barnes, 3122 Oxford
Mrs. G. L. Blaine, 2428 Greenwood
Dr. Louis J. Broussard, 2708 Sherwood Way
Bishop Thomas Drury
Dr. R. M. Finks, Clinic-Hospital
Mrs. Marie Gabriel, 1930 St. Mary
Mrs. Elsie Gayer, Baptist Memorial Hospital
Mr. Jess Gilbert
Mr. J. M. Glasscock, 2525 Rice
Mr. William Gorman, 3401 Oxford
Mrs. Pansy Gross, 2544 Colorado
Mr. Dick Howard, City Hall
Mr. Don Hulse, West Texas Therapy Center
Mr. Clarence Johnson, Edison Junior High School
Mrs. Elizabeth Jones, 1502 Kenwood
Mr. L. W. Keilers, Texas Employment Commission
Mrs. Hilda Kirchman, 122 W. First
Lt. Neville Lawton, 214 Windham
Miss Frances Lewis, Courthouse, Abilene
Mrs. Beulah Livingston, 12 W. 34th
Mrs. A. J. McDaniel, 1711 N. Magdalen
Mrs. Joan McGee, 122 W. First
Mr. G. E. Neely, 5346 Fruitland Farm Road
Mr. D. Gaither Paddock, 2530 Guadalupe
Mr. H. E. Rader, State Department of Public Welfare
Dr. W. B. Rountree, 703 W. Washington Drive
Mr. J. B. Strickland, First Savings Building
Dr. Everett L. Sutter, 2719 W. Harris
Mr. Rama G. Sweet, 3217 S.A.C.

San Antonio

Mayor: W. W. McAllister, Sr., P. O. Box 9066, 78200

Mayor's Commission Chairman:
Sam Jorrie, 1315 San Pedro

Members of the Commission:

Dr. Howard Britton, 3111 San Pedro Avenue
Miss Mary Louise DeLeon, Bexar County Child Welfare, 3A Life Building
Dr. Wayne Gill, 2310 Tower Life Building
Dr. Kenneth Kramer, c/o Psychology Department, Trinity University
Mr. James Lewis, 401 West Nueva Street
Dr. Robert Rast, 5800 South Presa Street
Mrs. Rix Rutland, 932 Creekview Drive

San Benito

Mayor: Edgar Ogdee, P. O. Box 1870, 78586

Mayor's Commission Chairman:
John F. Barron, 500 North Dowling

Members of the Commission:

Mrs. H. H. Baker, 801 North Bonham
Mrs. Chrissie Bucklin, Route 3, Box 130
Valdamar Garcia, 286 Victoria Circle
Mrs. Nelson W. Haas, M.D., 505 South Sam Houston
Pauline Pace, 1513 East Tyler, Harlingen
E. D. Peek, Route 1, Box 43

Sherman

Mayor: Ralph Elliott (first part of study), G. R. Stephens, 1427 North Woods (completion of study)

Mayor's Commission Chairman: Don R. Logan, 515 North Wood Street (first part of study), Roger Harvey, 1806 North Highland (completion of study)

Members of the Commission:

Mr. Lawrence Anderson
Rev. Stanley Hovatter
Mr. Willie Jacobs
Dr. Virginia Love
Mr. Lloyd Perkins
Rev. J. Allen Smith
Dr. Mary Jo Tonelli

Temple

Mayor: Wilfred B. Pitts, Municipal Building, 76501

Mayor's Commission Chairman:
The Rev. James LeFan, Box 3764

Members of the Commission:

Mrs. Hazel Bond, 1917 South 39th
M. L. Brizendine, 912 Fannin Loop
Dr. John Bryson, 509 South 9th
Mrs. Ruth Cook, 1706 North 13th
Bill Elam, 216 West Avenue H
Sam Farrow, 902 North 10th
Dr. Joe Greenwood, 517 West Shell Avenue
S. R. Greenwood, 112 North 6th
Dr. Thomas Hill, 3104 West Avenue T
Rep. Glenn Johnson, 601 West Zenith
P. D. Johnson, 1432 East Avenue C
Rev. Wilson Keenan, 2510 Bird Creek Drive
Ray Martin, Brooklawn Drive
A. J. Mercer, Jr., 1505 East Avenue B
Mrs. H. T. Stewart, 3606 Las Cienega
Miss Olive Jane Strange, 804 North 13th
William J. Valigura, Jr., 2505 Monticello Road
Dr. J. S. Weinblatt, 609 Fannin Loop

Texarkana

Mayor: Neal Courtney, P. O. Box 1967

Mayor's Commission Chairman:
Robert W. Case, 3702 Ghio-Fish Boulevard

Members of the Commission:

E. O. Bone, Texarkana School System
Mrs. Robert W. Case, 3702 Ghio-Fish Boulevard
Dr. J. W. Donaldson, 4006 Spring Lake Park Road
Cliff Edwards, Texas Employment Commission
Stern Feinberg, 3939 Ghio-Fish Boulevard
Dr. Lorie Hildreth, 17 Meadow Lane
William Hughes, Texarkana City Police Department
Jack R. Martin, Wadley Hospital
Robert A. Martindale, Texarkana Sheltered Workshop
Dr. J. E. Rorie, Collom and Carney Clinic
Mrs. Harold Terry, 3424 Walnut
Mrs. W. D. Thornton, 1201 Canadian
W. T. Westbrook, Bowie County Health Department

Texas City

Mayor: Emmett F. Lowry, P. O. Box 2608, 77590

Mayor's Commission Chairman:
The Rev. James R. Maples, Box 2788

Members of the Commission:

Mr. Wise Adams
Mr. Jack Alexander
Mr. Art R. Anderson
Mrs. W. G. Bir
Dr. Arr Nell Boelsche
Mrs. Howard P. Broderson
Mr. Otto Brotherton, Jr.
Mr. Lester Burks
Miss Dianne Clamon
Mrs. Joan Courtney
Mr. Leon Cox
Rankin DeWalt
Mrs. John Fox
Mr. Charles Hancock
Mrs. W. R. Holmston
Mr. Jim Jackson
Mrs. J. E. Jacobson
Dr. James E. Johnston
Dr. J. M. McAllister
Roland Matthews
Dr. Julian W. O'Bryant
Mrs. Julia Parks
Mrs. George Rasor
Mr. Stan Sheppard
Mrs. Allen Sneed
Mrs. Max Willard

Tyler

Mayor: Tom M. Clay, Peoples National Bank Building, Room 1010, 75601

Mayor's Commission Chairman:
Robert L. Cook, 3204 Jan Avenue

Members of the Commission:

Mr. Dan Chamness
Mr. A. M. Dullnig
Mr. D. K. Huffman
Mr. E. C. Kennedy
Judge Harry Loftis
Mr. Clyde H. McLendon
Mr. Thomas Sproule

Victoria

Mayor: Kemper Williams, Jr., P. O. Box 1758, 77901

Mayor's Commission Chairman:
George A. Constant, M.D., 306 North Moody

Members of the Commission:

M. E. Cerda, 3106 Cedar
Hon. R. H. Cory, 112 West Forrest Street
Richard Danko, Devereaux School, County Airport
Richard Grant, 1201 East Poplar
John Guseman, 105 North Bridge Street
Mrs. Jennie Jo Hawkins, 2805 Meadowlark
Mrs. J. D. Howell, 512 West Colorado
Dr. Richard Hungerford, 1401 North Glass Street
Mrs. Alice Kinchion, 602 East River Street
Mrs. Louis Kleinecke, 1908 East Crestwood
Mrs. Mary F. McCall, Hopkins Elementary School
Sheriff Monte Marshall, Victoria County Court House
Mr. Bob Martin, Radio Station KNAL
Mrs. Thomas Martin, 3003 Bluebonnet Drive

Rev. Harold Pierson, First English Lutheran Church
Mr. Morris Roberts, 608 West Goodwin Avenue
Harry Uthoff, 2504 Poplar Avenue

Waco

Mayor: Roger N. Conger (first part of study), Ernest Pardo, City Hall (completion of study)

Mayor's Commission Chairman:
Mrs. Sam Appell, 2605 Starr Drive

Members of the Commission:

Mr. James C. Dalton, 1501 North 18th
Mr. Frank Davis, 500 Valley Mills Drive
Mrs. Frank Karaffa, 3021 North 43rd
Mrs. Crawford Malone, 4308 Cedar Mountain Drive
Miss Pauline Reid, c/o Jefferson Elementary School, 315 Jefferson
Mrs. Jan A. Ronk, 2208 Alexander

West University Place

Mayor: Du Pree Holman, 3800 University Boulevard, 77000

Mayor's Commission Chairman:
Curtis E. Posey, 6340 Auden, Houston

Member of the Commission:

Mrs. Lee Lockard, 3811 Swarthmore, Houston

Wichita Falls

Mayor: J. Winston Wallander, P. O. Box 1431, 76301

Mayor's Commission Chairman:
Arthur Tipps, 3200 Speedway

Members of the Commission:

Miss Patsy Baggett, County Courthouse
Mrs. Thelma Fillmore, 2618 Bretton
G. H. Kirby, 1105 Holliday
Dr. Joe B. McNiel, 1105 Holliday
Dr. Charles Parker, Wichita County Health Unit
Dr. Harlan Steph, Midwestern University
Mr. John Weimer, 3401 Armory Road

CHAIRMEN, STATE AGENCY PLANNING COMMITTEES

Charles D. Barnett, Ph.D., Deputy Commissioner for Mental Retardation, Texas Department of Mental Health and Mental Retardation

Don Partridge, Director, Division of Special Education, Texas Education Agency

Howard Masden, Assistant Director, Texas Youth Council

Ted Mitchell, State Supervisor, Program of Services to the Handicapped, Texas Employment Commission

Carl F. Moore, M.D., Director, and Paul Manning, Division of Maternal and Child Health, Texas State Department of Health

Herbert Wilson, Assistant Commissioner, Texas Department of Public Welfare

STATE PLANNING OFFICE STAFF

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Charles Meisgeier, Ed.D., Special Consultant

John L. Jackson, Assistant Planning Director

Preston Clark, Health Program Specialist

Mrs. Elizabeth D. Bush, Secretary

Mrs. Ruth Piper, Secretary

Mrs. Avis Nissen, Secretary